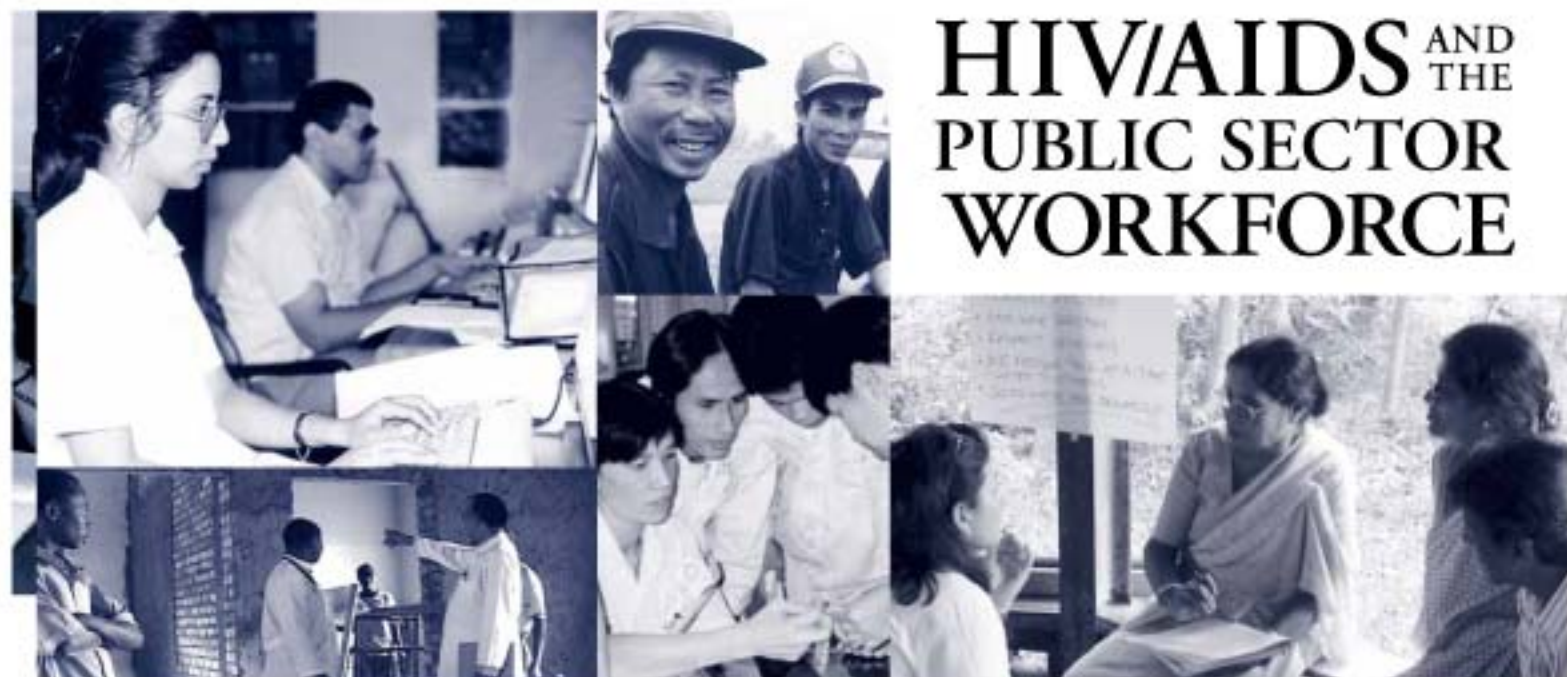


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# HIV/AIDS AND THE PUBLIC SECTOR WORKFORCE

An Action Guide For Managers



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# HIV/AIDS <sup>AND THE</sup> PUBLIC SECTOR WORKFORCE

**An Action Guide For Managers**

By Bill Rau



## WHAT READERS SAY ABOUT FHI'S *PRIVATE-SECTOR WORKPLACE GUIDE*

"Before reading the FHI Action Guide for Managers, we viewed HIV/AIDS only as a social issue far from our business operations. The guide clearly describes why companies need to get involved in HIV/AIDS prevention, as well as the benefits for doing so. Our company runs a nationwide distribution operation with over 1,200 drivers. We now realize that HIV/AIDS could impact our distribution network."

*Angky Camaro, Managing Director  
Sampoerna, Indonesia*

"A well thought-out and practical guide. As an HR Manager I have used it as a reference and developed a customized HIV and AIDS workplace program for one of the leading hotels in Kenya, a program that was assessed ... as one of the most comprehensive in the hospitality industry in Kenya by the National AIDS Control Council."

*Simon N. Mwangi, human resources manager  
Bayer East Africa*

"As an organization charged with strengthening workplace responses to HIV and AIDS in Kenya, we found the guide to be user-friendly and exactly what we needed. The content has greatly enriched our management sensitization program, and most of the companies that we are working with have developed a strong sense of ownership of their HIV and AIDS programs."

*Philip Waweru, program manager, National  
Organization of Peer Educators (NOPE), Kenya*

"This guidebook is perhaps the only one of its kind. It has proved to be a great help to companies and NGOs (that are) planning programs because it is simple and logical and encompasses all the relevant details needed for running a good program."

*Rupam Nangia, consultant on management  
and HIV/AIDS in the workplace  
Mumbai, India*

"The book was particularly useful when workshops for companies that intended to develop HIV/AIDS workplace policies were organized. The book talks about the direct economic impact of HIV/AIDS on businesses, individuals and households — this information was useful during the program implementation, sensitization and advocacy with top management and staff. The book has also served as resource material for the development of a national AIDS policy."

*Frimpong Addo, program officer  
Private Enterprise Foundation  
Accra, Ghana*

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FHI will provide copies of *Workplace HIV/AIDS Programs: An Action Guide for Managers* at no charge to users in developing countries. To request a copy, write [aidspubs@fhi.org](mailto:aidspubs@fhi.org)

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The material in this guide incorporates more than two decades of experience of Family Health International (FHI) and The Policy Project in HIV/AIDS prevention, care, treatment, policy development and economic analysis. Both organizations have worked closely with their partners around the globe to learn and apply lessons that will assist governments, businesses and communities to control HIV/AIDS and its effects.

This guide is a companion to *Workplace HIV/AIDS Programs: An Action Guide for Managers*, which was designed to help address HIV/AIDS in the private sector. We have adapted some of its features here, so people familiar with that guide, published by FHI in 2002, will find some similarity with the steps for developing public sector programs.

Material for this guide was collected in 2003 in interviews with government and public sector union officials in Brazil, Ghana, India, Tanzania and Zambia. We are grateful for the insights, information, and cooperation of those officers. We also acknowledge the offices and staff of FHI and The Policy Project in those countries for their help arranging interviews and gathering documents.

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**Cover photos, clockwise from top front of front cover:** Data entry in Egypt, Sandor Balogh/FHI; bicycle messengers in Viet Nam, Tran Thi Hoa; adolescent health training in India, Tita Oronoz/FHI;

Bangkok factory workers discussing proper condom use/FHI; Physicians preparing site for ART delivery in Rwanda, Rob Ritzenthaler/FHI; Page 5, Cedric Nunh/Panos Pictures; Pages 17, 33, 43, 67, Tran Thi Hoa; Page 61, Panos Pictures; Page 72, Ritzenthaler/FHI; nursing office in El Salvador, Tita Oronoz/FHI (on book spine); Kevan couple, Ace Communications; Nepalese men, Mary O'Grady/FHI.

**Chapter divider photos, clockwise from top front of front cover:** Data entry in Egypt, Sandor Balogh/FHI; bicycle messengers in Viet Nam, Tran Thi Hoa; adolescent health training in India, Tita Oronoz/FHI; Bangkok factory workers discussing proper condom use/FHI; Physicians preparing site for ART delivery in Rwanda, Rob Ritzenthaler/FHI; Page 5, Cedric Nunh/Panos Pictures; Pages 17, 33, 43, 67, Tran Thi Hoa; Page 61, Panos Pictures; Page 72, Ritzenthaler/FHI; nursing office in El Salvador, Tita Oronoz/FHI (on book spine); Kevan couple, Ace Communications; Nepalese men, Mary O'Grady/FHI.

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## INTRODUCTION

### ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drug
AZT	Azidothymidine
BCC	Behavior change communication
HIV	Human immunodeficiency virus
ILO	International Labour Organization
NGO	Nongovernmental organization
NVP	Nevirapine
PLHA	People living with HIV/AIDS
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

### USE OF TERMS

Throughout this guide, *government sector* and *public sector* are used interchangeably.

The more than 190 national governments and thousands of local government and quasi-public authorities across the world use numerous terms to describe their government ministries and agencies. For example, some governments call their major components *ministries*, whereas others refer to them as *departments*.

*Ministry* refers to a major government unit, such as a ministry of finance or ministry of agriculture. It can also refer to a similar department, where that term is used.

*Agency* refers to a part of a ministry or quasi-independent entity. The teaching service, usually located within a ministry of education, is an example. A quasi-independent part of government may include a technology development institute, for example.

Occasionally, *unit* or *government unit* is used to describe any part of the government.

The guide uses *public service* and *civil service* interchangeably to refer to all government units. *Private sector* refers to businesses that are privately owned and controlled.

Currency amounts are expressed in US dollars (\$), unless otherwise noted.

## INTRODUCTION

**Government bodies are the largest employer in** many countries, but too little attention has been given to strengthening HIV/AIDS prevention, care and treatment programs for government employees and their families. This book offers practical guidance on creating or expanding HIV/AIDS workplace programs for civil services.

HIV/AIDS is having a serious effect on government employees and on the functions they perform. The decreasing ability of government offices to carry out their assigned tasks has ripple effects across all of society. The policy, oversight, and service delivery roles of government are interdependent. Disruptions at one place or level will influence the effectiveness at others. Absences, illnesses, deaths and early retirements due to HIV/AIDS have profound implications for economic development and social welfare.

Unlike individual companies in the private sector, government ministries play multiple roles and responsibilities in society. Private sector companies make decisions to maximize their profits. Government offices make decisions to promote the smooth functioning and welfare of society. Actions by government affect the economic, social, security, and cultural well-being of all sectors of society. These contrasting, though sometimes overlapping, motivations of the public and private sectors call for different approaches to addressing HIV/AIDS in the workplace.

The guide is designed for human resource managers, employee welfare managers, medical officers and labor representatives in government ministries and agencies. It will assist in designing and developing effective

and appropriate prevention, care, and support programs, and in mitigating the effect of staff losses due to HIV/AIDS in the public workplace.

It is not necessary for every government ministry to develop all the services needed for comprehensive HIV/AIDS prevention, care, and treatment programs; in many instances, those services exist in the community, and duplicating what exists is both costly and unnecessary. But it is important that workers and their dependents know where to find services that meet their needs. Providing that information will be a critical part of a ministry response.

The guide is intended to be a basic reference tool. Users can select chapters to assist with specific aspects of an HIV/AIDS program. Checklists are included for assessing the effects of HIV/AIDS on a particular workplace and for developing HIV/AIDS workplace policies or programs. And the guide suggests resources for additional assistance.

Given the diversity of countries and their experiences with HIV/AIDS, the guide offers a flexible set of options and recommendations. The complexity of HIV/AIDS situations requires flexible responses; the guidelines offered here are meant to be adapted to fit different needs. Further, addressing HIV/AIDS is a task for all sectors of society. Most governments



have assumed responsibility for leading the national responses to HIV/AIDS. But in many instances, those responses have not included comprehensive HIV/AIDS programs for the government's own workforce.

The guide provides:

- Information on the effects of HIV/AIDS on government ministries, employees and the functioning of national services. Such information can be used to assess the risk faced by individual countries or ministries and to sensitize others about the need for prevention, care, and mitigation programs and policies in the workplace.
- Information on the essential components of effective and appropriate HIV/AIDS prevention, care and mitigation programs and policies for the public sector. This information will help human resource managers plan and implement programs, and addresses the issue of retaining outside help when needed.

- Methods to gain the support of senior management and employees for adopting and implementing HIV/AIDS workplace programs and policies.
- Background information on HIV/AIDS as a disease.
- The experiences of countries that have already adopted and implemented workplace prevention, care, or mitigation programs or policies, or a combination of these.

Resources, examples, and experiences incorporated in this guide were gathered in a series of interviews with governmental and nongovernmental officials in Brazil, Ghana, India, Tanzania and Zambia. The vast networks of FHI and The Policy Project provided background material for use in several of the case studies.

## CHAPTER ONE

### HIV/AIDS IN THE WORKPLACE



This chapter covers:

- The importance of HIV/AIDS programs for the public sector
- A rationale for adopting or expanding workplace HIV/AIDS programs
- Information sources to get started



**The rapid spread of HIV/AIDS is having an increasingly adverse** effect on the operations and efficiency of many government ministries and agencies, and on employees' families. In countries and communities where HIV/AIDS is most concentrated, the ability of government employees to deliver services, maintain the functioning of common tasks, and fulfill government development plans has been compromised.

Losses of personnel to HIV/AIDS have been most evident in the education and health sectors. Workers in these sectors are critical for maintaining public welfare and contributing to longer-term development. But the effects of HIV/AIDS are not confined to any one ministry; they are spread across governments and can be discerned at all levels.

The civil service is the largest formal-sector employer in many countries. In other countries, government employees constitute a major portion of waged and salaried workers. Civil servants may represent between one-quarter to well more than half of all workers in the formal sector. They earn regular incomes and pay taxes. The loss of civil servants affects the functioning of government and its financial base. As gaps in government efficiency occur, citizen respect for government may wane, leading to social unrest and frustration. Citizen support and participation in governance is curtailed, as more people develop terminal diseases and are removed from the public sphere. This also affects civil society's capacity to take part in public debates, depriving society of its ability to build and sustain national cohesion.

In addition, many government departments are finding that some employees experience long periods of absenteeism, significant out-of-pocket expenses for medical care, and the stress and trauma of caring for family and

friends who are ill. Increasingly, ministries are including the costs of HIV/AIDS treatment in their annual budgets.

Whether a country is experiencing low, moderate, or high HIV prevalence, AIDS is now affecting all managers, workers' representatives and civil servants. It affects the daily work of supervisors and human resource planners within ministries and civil service commissions. It affects employee welfare and morale, as well as the efficiency of regular operations. And it must now be considered an important factor in the management and welfare of the public service.

### 1.1 HIV/AIDS AS A WORKPLACE ISSUE

Because businesses face financial losses if their workers are not productive, a fair amount of attention has been given to addressing HIV/AIDS in the private sector workplace. Although similar concerns exist in the public sector, less attention has been given to HIV/AIDS in the public sector workplace.

Government ministries and agencies are generally not set up to make a profit, as are businesses. But governments have major responsibilities that influence countries' economic, social and environmental well-being. If a nation's workforce is hampered by extensive absenteeism, loss of trained and skilled work-

ers, or mounting personnel costs, the government's ability to fulfill its responsibilities is compromised. HIV/AIDS makes it increasingly difficult for ministry employees to do the jobs they were hired to do. The cost of managing HIV/AIDS is causing a shift in money from planned development functions to unplanned personnel expenses. AIDS is putting new pressures on managers to perform with limited resources, and is diverting workers' attention from their daily tasks to worrying about infected family members or their own health.

For a decade or more, some governments have been under pressure by international donor agencies to implement changes in the structure and functions of their civil service. Some of the changes involve downsizing the civil service (i.e., retrenchment), reducing the role of government agencies in running the country, altering personnel responsibilities, and changing salary and benefit plans to match new realities.

Especially in Africa, many public servants believe their salaries are too low and their work too difficult. The departure of staff for more lucrative positions in the private sector, with nongovernmental organizations (NGOs), or with international agencies has affected ministries over the past decade. Many highly trained, skilled personnel are being recruited to fill vacancies in European and North American countries. The steady attrition of key personnel compromises ministries' ability to deliver the services expected of them.

HIV/AIDS adds new dimensions to these existing challenges—often in unexpected ways. Some human resource personnel have privately suggested that the epidemic has unwittingly assisted the government in its downsizing efforts. But this cynical view is at odds with effective planning. HIV/AIDS does not target specific employee categories; it cuts across the spectrum of worker categories and skills. AIDS

is increasing the cost of maintaining the government workforce, perhaps inducing unanticipated cuts in positions or benefits to absorb these added costs. And AIDS strikes at the heart of government's primary role: providing a range of social and economic services to the public and private sectors. Teachers absent from the classroom, customs officers absent from cargo clearing stations, or health personnel so overworked they cannot provide quality patient care—all are realities in the era of HIV/AIDS and all undermine the government's role in society.

Like other challenges in reforming the government workforce, HIV/AIDS is a factor that must be considered in planning, operations, and supervision.

Disruptions are not limited to highly trained employees. Mail delivery, vehicle maintenance, or cleaning of offices and hospital wards all involve specialized or acquired skills and knowledge. Each task contributes to the smooth functioning of government ministries. Without staff to carry out these tasks, other employees face additional constraints in completing their own work.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) provides an example of what it calls the "chain reaction" effect of HIV/AIDS.<sup>1</sup> The example begins with agricultural extension workers. An ever-increasing number of sick and dying agricultural extension workers results in a breakdown of field reporting on production, less time with key farmers, and delayed adoption of new technologies. Together, these factors make it harder for government planners to project production levels (and possible food security needs) and for farmers to efficiently produce and market their products. National policymakers and businesses have less information on which to make decisions about crop prices, and marketing, processing, and input requirements.

1. UNAIDS. HIV/AIDS, *Human Resources and Sustainable Development*. Geneva, 2002.

## 1.2 HIV/AIDS AS A LABOR ISSUE

Beyond affecting workers on the job, HIV/AIDS also causes a major drain on family savings and resources. Just as government ministries and departments experience increased expenses due to HIV/AIDS, so too do employees. Medical expenses are likely to rise, even if the employee has access to insurance or public medical facilities. Absences from work to care for a sick family member may affect household income.

While numerous governments have adopted policies with nondiscrimination provisions, many workers are reluctant to be tested for HIV or to disclose their serostatus to coworkers or supervisors. They fear losing their jobs or experiencing the social stigma that surrounds the disease. In several countries, labor unions and other worker organizations, such as Zambia's teachers' union, have worked with the government to develop public sector HIV/AIDS workplace policies and programs. One of the biggest concerns of workers' groups is protecting employees from discrimination, from unfair and unwarranted dismissal, and from denial of benefits because they are (or are believed to be) HIV-positive.

Unions also face rising costs. Many unions provide a death or funeral benefit to dependents. A union may supplement other benefits provided by the government to its employees. As more union members become ill, retire or die, union costs rise, probably beyond expected increases.

## 1.3 WORKPLACE HIV/AIDS RESPONSES

A comprehensive HIV/AIDS program for the public sector workforce will include three broad categories: prevention, care and treatment, and mitigation. Each of these categories has several subtopics. They are outlined here and discussed in detail in subsequent chapters.

### HIV/AIDS Prevention in the Workplace

- An HIV/AIDS workplace policy
- A comprehensive HIV/AIDS prevention program

### Care and Treatment for Employees

- Access to facilities for managing STIs
- Access to facilities and drugs for treating opportunistic infections
- Access to antiretroviral therapy (ART) and associated medical and laboratory monitoring
- Information about support services available in the community

### WHAT DO WE MEAN BY WORKPLACE HIV/AIDS PREVENTION PROGRAMS?

HIV/AIDS prevention involves several related components. Proven and effective HIV/AIDS prevention programs address:

- Individual knowledge about the disease, how it is transmitted (and not transmitted), and what can be done to prevent transmission of the virus.
- Support for changes in sexual behavior and sexual norms to reduce the number of sexual partners, sexual harassment, and manipulation of women, and to postpone early sexual relations among young people.
- Access to services for managing sexually transmitted infections (STIs).
- Access to a range of services to prevent or reduce harm related to drug misuse.
- Access to and promotion of male and female condoms for use with non-regular sexual partners.
- Access to and promotion of HIV testing and counseling facilities and services.

### Mitigation

- Good information systems to track personnel changes
- Plans and options for managing additional financial costs associated with HIV/AIDS among employees
- Plans and options for changing personnel procedures to sustain work efficiency
- Options for providing new, additional, or reduced assistance to infected and affected employees
- Plans and options for replacing personnel

#### WHAT DO WE MEAN BY WORKPLACE HIV/AIDS CARE AND TREATMENT PROGRAMS?

- Access to and promotion of social support networks and services for people who are infected and affected by HIV.
- Changes in workplace functions to reduce the stress on infected and affected workers.
- Thorough information on sources of appropriate medical, health, and nutritional services for infected individuals, including for related illnesses such as tuberculosis.
- Thorough and regularly updated information on home-based care and support services for family members.
- Where offered, full and private access to workplace HIV counseling and testing services—or information on where such services exist outside the workplace.
- Assistance locating appropriate medical services.
- Where offered, full and private access to antiretroviral (ARV) drugs, including drugs for preventing mother-to-child transmission of HIV.

Several components overlap. For example, the workplace policy is likely to address prevention, care and treatment, and aspects of mitigation. STI management is as important to prevention as it is to treatment programs. Employees' dependents may be included in some or all aspects of the government's HIV/AIDS response.

### 1.4 MULTISECTORAL RESPONSES TO HIV/AIDS

There has been much emphasis on building multisectoral responses to HIV/AIDS, but confusion remains about what the term means and how it can be applied by government ministries.

The pandemic affects a person and a household's economic well-being, social status, access to basic social services, and ability to contribute to local and national development. These multiple dimensions require a multisectoral response. A multisectoral response means that the social, economic, cultural and political realities that shape society are taken into account in developing and implementing HIV/AIDS programs. The approach is similar to approaches taken to national development. Priorities are set and plans are shaped by individual ministries within the scope of their roles and responsibilities. These are then blended into an overall national strategy.

Using their skills, organizational structure, and internal communication processes, all government ministries can contribute to a broad HIV/AIDS program. It involves providing prevention information to employees, implementing workplace standards and procedures that minimize risk of infection, and informing employees and their dependents about community prevention and care services. It does not mean that each ministry or agency must develop a full set of prevention and care services in its own setting. Existing government

and community services can and will be used, supplemented by some ministry inputs.

A multisectoral response also means continuing the tasks assigned to the ministry or agency and incorporating into those tasks ways to expand responses to HIV/AIDS. Many ministries of education are already doing this by incorporating HIV/AIDS information into the classroom curriculum. Teachers are not being required to become specialists on HIV issues, but they are required to use their communication skills to help children learn about ways to prevent AIDS, as is occurring in Brazil.

A multisectoral response does not seek to retrain staff to become AIDS specialists to work with their constituents. Adding to the existing workload is often resisted, no matter how attractive the rationale may appear to planners. A more realistic approach is to encourage staff to do what they have been hired to do and to build aspects of HIV/AIDS into those functions. In agriculture, for example, staff are expected to understand cropping patterns, production methods, or marketing. Each of these can be shaped, with little additional training, to include an HIV perspective, either in data generation, analysis or planning. Thus, agricultural extension workers need not promote condoms to their constituents. But they can monitor changes in land use for crop production or changes in labor availability for farm work—changes that could occur because of the effects of HIV/AIDS on households.

## 1.5 STRENGTHENING THE PUBLIC SECTOR

This guide provides both short-term and medium-term options to reduce the effects of the epidemic on public sector staff. The options outlined here lead, in turn, to longer-term planning to strengthen government ministries being confronted with new crises. Many reforms to reduce the role of government in economic management have, however, left

### WHAT DO WE MEAN BY HIV/AIDS MITIGATION?

Mitigation takes two forms:

- 1) Reducing the impact of HIV/AIDS on the functioning of the workforce:
  - Adjusting the workforce as a result of personnel losses
  - Adjusting hiring and training practices to account for real and planned staff losses due to HIV/AIDS
  - Adjusting benefits so that new costs associated with HIV/AIDS can be managed by the public sector
  - Adjusting the civil service (or teaching service/uniform services) general orders (sometimes called the standing orders) that guide the management of government employees
- 2) Reducing the impact of HIV/AIDS on individual workers and their families:
  - Thorough information for workers and families on existing benefits and on any changes made to benefit plans
  - Helping workers and families arrange financial affairs
  - Helping workers and families arrange legal affairs (such as preparing wills)

some ministries less than adequately staffed to carry out the duties still expected of them.

As plans are drawn to lessen the effects of HIV on staffing levels and staff efficiency, managers should also give consideration to replacing staff lost to the disease, to retirement, and to private or NGO employers. At the same time, replacement and new staff must have the infrastructure, equipment, and resources to perform their jobs. Protecting government employees (and their dependents) from AIDS



#### WHAT DO WE MEAN BY AN HIV/AIDS WORKPLACE POLICY?

- A policy that provides guidelines on employer and employee rights and responsibilities in the context of HIV/AIDS
- A policy that promotes gender equity in accessing prevention, care and treatment services and benefits
- A policy that promotes confidentiality for infected and affected workers
- Efforts to discourage discrimination and stigma directed against people who are or might be HIV-infected
- Thorough information on existing policies, procedures, and benefits, and guidance on how to access appropriate benefits
- A policy that guides managers in dealing with individual cases
- A policy that outlines conditions for healthy and safe work environment

and its economic and social effects can be a critical step in the longer-term rebuilding of key civil service staffing categories. Many countries need more health, education, training, community development, and other staff to support economic development.

The impact assessment guidelines offered in this guide (see Chapter 3) are especially useful in strengthening the public sector. Many government ministries and agencies do not have a good profile of their staffing gaps. An impact assessment can provide needed data for medium-term and longer-term planning, and for advocacy to acquire adequate resources and staff to promote national development goals.

#### 1.6 FINDING USEFUL RESOURCES

Creating, expanding, or revising a workplace HIV/AIDS program can seem like a major challenge. But there are numerous resources to assist in the task. Some useful resources appear at the end of this guide. Many others are available locally.

Because governments and nongovernmental agencies have extensive experience in designing and implementing HIV/AIDS policies and programs, a first step is to identify local resources and experiences. What information sources, technical expertise, services, educational materials and supplies exist locally? What is the experience within ministries/agencies, NGOs and private companies? Who can help design and implement a policy or program?

The following options can provide insights:

- Talk to colleagues in other sections of the ministry or another ministry.
- Ask local health and social service authorities about relevant experiences.
- Talk to NGOs that work with HIV/AIDS, youth, women or health issues.
- Check newspapers and listen to radio or television for stories that mention groups involved in AIDS.
- Consult with the National AIDS Commission or the National AIDS Control Program.
- Talk to private sector companies; many have experienced the effects of HIV on their operations and some have developed HIV/AIDS workplace programs.

## CHAPTER TWO

### HIV/AIDS BASICS



This chapter covers:

- Information on HIV transmission and AIDS as a disease
- Information on ARV drugs and therapy
- What is known about longer-term control of HIV/AIDS
- Useful comparative experiences from the private sector



**HIV was identified by scientists approximately 25 years ago.** Once a person is infected with the virus, it can take as few as two or three years, or as many as 12 or 15 years, for it to weaken the immune system. In the latter stages of infection, the immune system may be so weakened that symptoms of other diseases—opportunistic infections—appear; a person with HIV now has AIDS (see Glossary).

Receiving appropriate treatment for these opportunistic infections (such as tuberculosis) prolongs the life of someone with AIDS. Even with treatment for opportunistic infections, the immune system will continue to weaken and persons will eventually die of untreatable opportunistic infections.

As of early 2004, an estimated 40 million people globally have been infected with HIV. An equal number of people have already died of AIDS. HIV/AIDS is found in all societies and in all countries. It is not confined to any one locale. Nor is it limited to specific socioeconomic, racial, gender, age, or ethnic groups. It is a global disease. Social and cultural factors may play a role in a group's susceptibility to infection, but those factors have not provided a total barrier to the transmission of HIV.

## 2.1 HIV TRANSMISSION

### How is HIV Transmitted?

A person can become infected with HIV by exchanging bodily fluids, such as semen or blood, with an infected person. Specifically, HIV infection can occur in the following ways:

- Having unprotected sexual intercourse—vaginal, anal, or oral—with an infected person

- Using needles or other skin-piercing instruments (such as razor blades or tattoo needles) contaminated with HIV
- Receiving a transfusion of HIV-contaminated blood
- Infecting fetuses/infants during pregnancy, birth, or breastfeeding

Because of biological and societal differences, women (especially young women) are generally more vulnerable than men to becoming HIV-infected. But both males and females are at serious risk for contracting HIV from an infected partner during unprotected sexual intercourse. The risk increases substantially if either person has an STI, or if the person is in the stage of HIV infection at which virus levels in the blood are very high. The period in which virus levels in the blood are high occurs immediately after infection and late in the disease, when the person is ill.

The World Health Organization (WHO) and UNAIDS suggest that about 10 percent of HIV infections occur through nonsexual transmission. There has been some disagreement about that proportion. Some authorities suggest that, especially in Africa, the deterioration of health systems has led to reusing needles in clinics and hospitals. These authorities suggest that HIV transmission via contaminated nee-

dles plays a much larger role in transmission than is commonly suggested. While attention clearly must be given to transmission in clinic and hospital settings, the debate about the total proportion of HIV infections caused by transmission in these settings continues.

#### **How is HIV Not Transmitted?**

HIV infection does not just happen. You cannot simply “catch” it like a cold or the flu. Unlike cold or flu viruses, HIV is not spread by coughs or sneezes, or by sharing drinking or eating utensils. HIV is not transmitted through sweat or tears.

HIV is not passed through everyday contact with people at work, home, school or anywhere else. One will not get HIV from clothes, telephones or toilets. It cannot be passed by sharing spoons, cups or other objects used by someone infected with the virus. One cannot get it from everyday contact, such as shaking hands with an infected person. Likewise, HIV cannot be contracted from insect bites. HIV transmission requires exchange of bodily fluids containing the virus; none of the normal daily, non-intimate interactions involves exchange of bodily fluids.

#### **How is HIV Transmission Prevented?**

A major portion of HIV transmissions result from specific sexual behaviors. To reduce the risk of sexual transmission:

- Postpone the age of first sexual activity
- Abstain from sexual intercourse when you are not with your regular partner
- Reduce the number of sexual partners
- Use a latex condom
- Treat an STI
- Get tested for HIV with your partner

HIV transmission can be prevented—or the risk of infection reduced—with drugs. This includes:

- Treating HIV-infected pregnant women with ARV drugs during delivery
- Providing ART at appropriate times to people living with HIV/AIDS (PLHA)
- Providing ART at appropriate times following sexual assault
- Providing ART at appropriate times following blood exposure in an occupational setting

As noted, HIV can also be transmitted through nonsexual means. Health care workers should eliminate contact with blood by using protective materials (e.g., latex gloves), cleaning up body fluid spills with appropriate disinfectants, and by using appropriate disposal methods for waste. This will reduce the risk for transmitting HIV, hepatitis, and other blood-borne pathogens. In other workplaces, similar precautions are needed when tending to accidents (see Chapter 6 for further details). Most public health authorities or occupational health and safety officials can provide detailed information on implementing appropriate procedures to prevent or reduce the risk of HIV transmission during workplace accidents.

Needles, surgical knives and other skin-piercing instruments should be used only once, for one person, and then disposed. If one-time use is not practical, instruments should be properly sterilized between each use and before they are used on another person. Donated blood should be screened for HIV before being given to another person.

Sharing needles and other drug paraphernalia while injecting drugs carries the risk of HIV transmission via infected blood left in the equipment. In parts of South Asia, Latin America, the Middle East, and countries of the former Soviet Union, injection drug use has

become a common mode of HIV transmission. Injection drug use occurs in parts of sub-Saharan Africa, but is not common.

Reported rates of mother-to-fetus/infant transmission vary from 20 percent to 45 percent. Scientific studies indicate that the drugs AZT and nevirapine (NVP) reduce the probability of an HIV-infected woman transmitting the virus to her fetus. These drugs are not widely available in most developing countries, though significant efforts are underway globally to increase drug availability. There is evidence that using single and dual-drug antiretroviral prophylactic regimens (particularly NVP) results in a drug-resistant virus in exposed mothers and infants. The significance of this resistance and its impact on future treatment outcomes for women and infants who develop HIV infection are not known. So if there is reason to believe that either partner may be HIV-infected, it is prudent to encourage voluntary HIV counseling and testing for each partner before conceiving a child. Other important means to prevent mother-to-fetus/infant transmission are:

- Preventing unintended pregnancies in HIV-infected women through family planning
- Preventing HIV infection in women of reproductive age
- Making infant-feeding formula (and counseling regarding its use) available to HIV-infected women who are able to use it safely (e.g., with access to a safe water supply)

## 2.2 ANTIRETROVIRAL THERAPIES

Since the late 1990s, significant strides have been made in developing drug therapies for PLHA. Multidrug therapies are giving way to simplified dosing regimens. The cost of ARV drugs has fallen to levels that are more affordable to governments, businesses, and private citizens. Training of medical and laboratory providers has resulted in effective backup support for people who receive the drugs.

ARV drugs are usually given when the CD4 count (a laboratory measure of the number of CD4 cells in the blood, a critical measure of immune system function) falls below 350/ml, according to WHO recommendations. HIV-infected people whose immune status has not dropped to this point do not yet need ARVs. But they might need care to prevent opportunistic infections, as well as counseling to ensure healthy living habits to maintain their immune system function and avoid transmitting HIV to others.

ARV drugs attack HIV in different ways, depending on the drug and where it acts on the virus. Overall, they prevent the virus from duplicating and destroying immune cells. The immune system of an HIV-infected person then works more effectively, fighting off opportunistic infections and prolonging life. It is important to note that the drugs do not work for everyone. A small percentage of people who initiate ART die within several months, probably because they were diagnosed and began treatment too late. Some people are infected with virus that is already resistant to the drugs; in others, resistance may develop over time, particularly if the patient does not adhere to instructions on taking the pills regularly. Some discontinue the drugs because of side effects. For most people who take ARVs, the prognosis is good, and their lives will be prolonged for at least several years.

## 2.3 REQUISITES FOR ANTIRETROVIRAL THERAPY

There are three key requisites for effective use of ART. The first is knowledge of HIV serostatus—that is, knowing whether one is infected with HIV. A growing number of sites—usually known as voluntary counseling and testing (VCT) centers—have been established where people can be tested for HIV. Testing is usually coupled with pretest and post-test sessions with trained counselors who explain the implications of the test and of the results. Persons

may also learn their HIV serostatus if they have blood tests for medical, employment or insurance purposes. In some countries, military recruits or persons proposed for long-term training are required to take a medical exam that can include HIV testing. In these latter cases, a person may or may not be told that an HIV test will be performed, or of the results.

The second requisite for effective ART is a functioning medical and laboratory system, with staff training to manage the effects of the drugs. Preparing staff is primarily a matter of specific training in managing HIV/AIDS, understanding the body's responses to the drugs, and interpreting laboratory results. To assure that medical personnel are sufficiently qualified to work with people receiving ARV drugs, several countries have designated specific medical providers, not the entire profession, to receive the training.

A more complex issue is assuring that health systems have the expertise and facilities to work with people receiving the drugs. Many countries have experienced a deterioration in health facilities over the past 10–15 years. Broken, lost or obsolete equipment is one sign of problems. In many instances, sites where ART is being offered have received new and additional support to function fully and effectively.

The third requisite is a steady supply of drugs. Interruptions in supply can cause interruptions in use. Because disruption also may result in drug-resistant strains of HIV, the drug supply system must be fully functional. This is both a logistical and cost issue that providers must consider when deciding to provide ART.

ART is for life and requires taking medicine every day. Skipping treatment could lead to viral resistance rendering the ARV drugs ineffective.

## 2.4 LONGER-TERM CONTROL OF HIV/AIDS

Specialists worry about the commitment of governments, communities, and civil society groups to take the actions necessary to control HIV/AIDS. A great deal of hope has been attached to widespread provision of life-prolonging drugs for PLHA. The drugs are one element of an overall effective response. Another element is ongoing prevention.

Prevention is essential to reduce the number of new HIV cases. A growing body of evidence from several countries demonstrates that prevention activities do indeed work. Changes in behaviors of youth, for example, are evident in Uganda and Zambia. Fears that the epidemic would spread rapidly in Cambodia have not come to pass. There, an aggressive prevention program encouraged men to reduce their patronage with sex workers and to use condoms when visiting sex workers (see Case Study 2 on one effective component of Cambodia's prevention campaign).

Widespread and effective use of ARV drugs can help slow the epidemic. While the drugs are not a cure, they reduce the level of virus in the body, thereby reducing the likelihood of transmission. Also, people who learn their HIV status are more likely to alter their sexual behaviors, which can lead to reduced transmission.

A willingness to learn one's HIV status is a major step for most individuals. People fear they may be HIV-infected and the subsequent consequences. The emotional, social and financial costs of infection keep many people from seeking HIV counseling and testing. The stigma associated with AIDS adds to people's reluctance to be tested. Government offices can help reduce these fears by having clear policies available to all employees, as well as active prevention programs that include stigma-reduction efforts.



Difficult political and social choices await countries over the next several years. One of the most difficult will be deciding who receives ART. Cost and supply factors are likely to be considerations that governments, companies, and individuals will have to weigh, at least over the next several years, as ART expands.

WHO hopes to reach three million people with ART by 2005 (known as “3x5”). The United States has adopted a plan (known as “2-7-10” goals) to treat two million people with effective ART, prevent seven million new HIV infections, and provide care for ten million PLHA by the year 2010.

Other bilateral and foundation programs plan to reach several million other people with treatment and care programs. The plans are impressive, but they have to be. As of 2002, fewer than 30,000 people in Africa had received ART; of the 2.2 million people who died of AIDS in the same year, many could have used the drugs. The numbers will continue to increase as people infected in past years learn their HIV serostatus. Thus, programs must be sustained over many years as more people are tested and seek treatment. The ability and willingness of governments and the international community to assure affordable drugs are available for all who want and need them will be an ongoing challenge.

Extensive research and field testing of vaccines against HIV are underway. But the complexity of the virus has made vaccine development difficult. For the past ten years, scientists have said that a vaccine was ten years away. That still seems to be the case.

## **2.5 COMPARATIVE EXPERIENCES WITHIN THE PRIVATE SECTOR**

Some private sector companies have found that the epidemic is undermining their skill base, reducing their productivity and cutting into profits. Both the public and private sectors

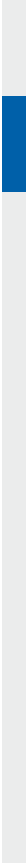
share a strong interest in retaining staff and controlling operational costs. Thus, some private sector experiences are useful to the public sector, including the need to:

- Acknowledge the risks associated with HIV/AIDS, for individual employees and for the organization's functioning
- Develop clear, accurate and current information about how HIV is affecting the organization
- Establish basic but comprehensive prevention programs (two decades of experience show that a comprehensive prevention program includes action-oriented information and encouragement, STI management, male and female condom distribution, and access to HIV counseling and testing)
- Prepare a policy that addresses all aspects of HIV/AIDS in the workplace
- Provide or arrange for employee/dependent access to drugs to prevent mother-to-child HIV transmission, and to treat opportunistic infections and HIV/AIDS
- Invest in projects that can be fully implemented and sustained, instead of one-time activities or pilot projects
- Provide staff with current information on government and community resources for HIV/AIDS, including testing and counseling, home-based care, STI treatment and legal services
- Be realistic about the costs of HIV/AIDS attrition and prevention, care and mitigation.

An overriding concern of many businesses is the cost of mounting HIV/AIDS programs. From a for-profit perspective, the concern should be assessed carefully.

By contrast, the public sector is primarily concerned with efficiency of service delivery, not





generating profits. Within the public sector, annual budgets rarely grow dramatically and trade-offs between line items are a regular occurrence. The private and public sectors are similar in protecting their investments in staff. Studies have shown that investments in comprehensive prevention programs are cost-effective—they pay for themselves by reducing absenteeism, death, and disruptions in productivity. Similarly, several large companies where HIV prevalence is high (about 10 percent) have concluded that providing staff with ART is generally cost-effective.

Private sector experience warns that HIV/AIDS requires sustained investments. Short-term solutions are inadequate for effective preven-

tion and for addressing the long-term effects of HIV/AIDS. Creating a budget line item for HIV/AIDS efforts is a critical step for any public or private sector organization.

There are ways to control and manage costs. One is to access existing information and services. The national AIDS control program is likely to have good prevention information and tools for developing or expanding HIV/AIDS activities. Numerous NGOs and some unions have experience in designing and implementing prevention and care programs. These experiences can be readily tapped to assist a ministry with its own program.

## CHAPTER THREE

### IMPACTS OF HIV/AIDS ON THE PUBLIC SECTOR WORKFORCE



This chapter will

- Provide evidence of the effects of HIV/AIDS on key government ministries and functions
- Provide examples of public-sector responses to protect their workforces
- Offer a structure for collecting information on the effects of HIV/AIDS on the workforce of a government ministry or agency



Although evidence that HIV/AIDS is having a serious effect on government ministries and departments is accumulating, it is fragmentary and incomplete, for a variety of reasons. First, many governments have been slow to fully address HIV/AIDS, both within the population as a whole and within the public service, so evidence about how AIDS affects civil servants has not been collected.

There are exceptions, of course, such as in the public sectors of Brazil, Senegal and Thailand, where state and national governments have moved quickly and effectively to control the epidemic. In many instances, however, only in recent years have governments mounted extensive prevention and care programs, including for their own workers.

Second, other changes in the civil service have masked the effects of HIV/AIDS on government workforces. Losses due to HIV are only one of several factors affecting the public sector. Others include:

- *Public sector reform programs underway in many countries.*<sup>2</sup> These reforms have resulted in significant civil service downsizing, especially for certain categories of workers. For example, recruitment by Uganda's Public Service Commission slowed significantly in the mid- and late-1990s, and many vacancies caused by AIDS deaths, retirements, and other reasons were not filled. A similar situation existed in Tanzania. The Ministry of Agriculture and Cooperatives indicated that the restructuring exercise within the Ministry

"masked" the problem of staff loss due to HIV/AIDS.<sup>3</sup>

- *Flight of civil servants to NGOs, private sector companies, international aid agencies, and other countries—commonly referred to as "brain drain."* Better salaries and working conditions are the primary reasons civil servants move to the private sector and international organizations. Loss of staff has been felt particularly in the middle ranks of the civil service.
- *Retirement of senior civil servants who have worked in the system over the past 20–30 years and who have substantial knowledge of the internal processes of government.*

Given these other factors, it is difficult (but not impossible) to identify the specific effects of HIV/AIDS.

HIV/AIDS has fallen outside the scope of regular government workforce planning, especially planning related to downsizing of a civil service during periods of reform. But given that HIV prevalence in the public sector workforce is likely to be similar to that in the general

2. In many instances, the reforms were imposed by donor organizations. They involved liberalization of the economy to allow greater flexibility of the private sector and privatization of businesses once held by government. Liberalization of economies has meant a smaller role for government in managing economic activities, and thus a smaller workforce to oversee those activities. The sale of parastatal companies (i.e., privatization) and contracting with the private sector to carry out functions previously handled by government employees (i.e., outsourcing) have removed many workers from the public sector payroll.

3. Topouzis, D. *Addressing the Impact of HIV/AIDS on Ministries of Agriculture: Focus on Eastern and Southern Africa*. FAO and UNAIDS, Rome, 2001, p.16.

population, human resource planners must factor-in potential staff losses and the added costs associated with HIV/AIDS.

Given the long lag time between HIV infection and associated illnesses, even where the affects of HIV/AIDS are not obvious or immediately seen, interventions are critical.

Many examples of impact are found in countries where HIV prevalence is high and where the epidemic has been evident for a number of years. In reviewing impact data, there is a tendency to dismiss the findings, assuming that lower prevalence or different socio-economic and cultural conditions make one's own country or ministry immune to similar results. While efforts are needed to minimize new HIV infections and to control the effects of the epidemic, the experiences of countries in southern and eastern Africa offer tangible insights into what can happen as the epidemic spreads.

### 3.1 IMPACT ON THE HEALTH SECTOR

The ability of health workers to deliver adequate and appropriate services for all clients is affected by staff losses to HIV/AIDS (and other reasons). In turn, the epidemic has increased the demands on health services, both in terms of the technical skills needed by staff, and in sufficient numbers of staff.

The loss of medical and health personnel to HIV/AIDS is especially evident in southern Africa. In South Africa, 15.7 percent of health workers in both the public and private sectors are living with HIV/AIDS. Among younger health workers (18–35 years), HIV prevalence is 20 percent. Some 6,000 health workers could be dying every year from AIDS-related illnesses. By 2015, deaths among health workers might be nearly five times greater than would be expected in the absence of HIV/AIDS.

In neighboring Botswana, an extensive national HIV/AIDS prevention and treatment program has been established. Nevertheless, the president of the country has noted that the number of trained medical staff has declined, due both to deaths from HIV/AIDS, and to people leaving public service to take better-paying jobs elsewhere.

Malawi's health services saw a threefold increase in staff deaths between 1992 and 2000, with the greatest losses occurring in the 30–44 age group. Along with other data, these changes indicate that HIV/AIDS has been a major (if not the major) factor in deaths of health staff. The deaths have occurred in all job categories, with the highest proportions among clinical officers, medical assistants and nurses. Further, already underserved rural primary care centers were finding it even more difficult to fill established posts, given the deaths and retirements from service. Without adequate staff to serve rural communities, the government's strategy to implement a comprehensive primary health care program was delayed and undermined. The cost of training replacements for the 290 paramedical workers who died between 1990 and 2000 was estimated at more than US\$220,000, excluding recruitment costs.<sup>4</sup>

The loss of nursing staff is especially evident in hospitals. Replacing nurses is difficult. At one large hospital in South Africa, 30 percent of available nursing posts and 20 percent of clinic nursing posts were vacant at any one time between 1998 and 2001. In Zambia, replacing nurses is made more difficult by the loss of nursing tutors at training institutions.

At a time when the efficiency and staffing levels of the health workforce is compromised by HIV, the demand for their services continues to rise, especially from PLHA. Not only is HIV/AIDS adding to the case load of health care

4. Malawi Institute of Management. "The Impact of HIV/AIDS on Human Resources in the Public Sector of Malawi." Unpublished report, 2002.

providers, but the complexity of the disease demands additional skills. For health care workers who remain in service, stress, overwork and exhaustion are common, which further undermines their ability to offer quality care. In South Africa, nearly two-thirds of medical personnel reported having taken sick leave because of the stresses they faced on the job. Morale has been affected, with more than one-third of health workers reporting that their attitudes were adversely affected by stressful working conditions, heavy patient workload, staff shortages and low salaries.

Many health staff are not able to offer the level of service they have been trained to provide, leading to high frustration. Lack of equipment, supplies, drugs, and other provisions lowers the care offered to all patients. Health care staff in Zimbabwe reported in 1998 that their real and perceived sense of not being able to offer effective care to patients was a primary reason for their resignation from government service.<sup>5</sup>

South Africa's Department of Health described how an increasing number of cases of HIV/AIDS and opportunistic infections has affected health service delivery. In preparing its 2002 budget, the department reported the following outcomes as demand for care and treatment grew:

- Fewer options for inpatient and outpatient care for persons with non-HIV-related conditions
- Inadequate quality of care for people with HIV-related conditions
- Very substandard care for a proportion of those sick with HIV/AIDS, especially in

locales and for groups with existing poor access to health care.<sup>6</sup>

The department argued that as the epidemic progresses and more people seek care and treatment, the ability of staff to provide adequate care to most presenting patients is being compromised.

### 3.2 IMPACT ON THE EDUCATION SECTOR

In several countries, the education sector has experienced severe and deep staff losses due to HIV/AIDS. In Zambia, teacher mortality was some 70 percent higher than in the general population, largely attributable to HIV/AIDS. As a result, teacher deaths equaled about two-thirds the output of teacher training colleges. In Central African Republic, UNAIDS reported in 2000 that schools were closing due to AIDS-related deaths of teachers.

In Botswana, one study projects that by the year 2010, the country will lose nearly 6 percent of primary school teachers and nearly 8 percent of secondary school teachers every year as a result of HIV/AIDS. The authors of the study state the obvious: "Mortality rates of this magnitude would have a very significant impact on teacher supply."<sup>7</sup>

In Malawi, 45 percent of Ministry of Education attrition between 1990 and 2000 was attributable to staff deaths. Nearly two-thirds of staff who died were between the ages of 30 and 44. Although the Ministry of Education did not collect data on sick leave, informal reports showed that at least one teacher was absent from school every day. In 2000, the ministry lost the equivalent of 6,760 months to staff absenteeism. Analysis of available information found that the cost of replacing primary and

5. Aitken, J.-M. with Kemp, J. *HIV/AIDS, Equity and Health Sector Personnel in Southern Africa*, EQUINET Discussion Paper Number 12, Regional Network for Equity in Health in Southern Africa (EQUINET), Harare, 2003.

6. South Africa, Department of Health. "An Enhanced Response to HIV/AIDS and Tuberculosis in the Public Health Sector—Key Components and Funding Requirements, 2002/03–2004/05." Pretoria, 2002.

7. Ministry of Education, Government of Botswana. *The Impact of HIV/AIDS on Primary and Secondary Education in Botswana: Developing a Comprehensive Strategic Response*. Gaborone, 2000.

secondary school teachers who died in the 1990s was nearly \$2 million—a major expense for a ministry already hard pressed to meet its responsibilities to students.

To simply replace teachers lost to HIV/AIDS, one province in South Africa would need to train 60,000 new teachers by 2010. The cost of training one new teacher is equivalent to more than \$10,000. Thus, replacing all teachers lost to HIV/AIDS will far exceed the education ministry's annual budget in the province. In Zambia, replacing teachers lost to HIV/AIDS will cost more than \$15 million by 2010, according to estimates.<sup>8</sup>

Many teachers, like others in government service, stay in their post when they become sick with an HIV/AIDS-related illness. But they take sick leave, often for days or weeks at a time. The result is that students lose learning time, classes double up to be covered by one teacher, and the quality of teaching and learning decreases. Teacher morale is affected by the loss of colleagues and the stress of working under increasingly demanding conditions. Children affected by HIV/AIDS bring their worries and fears to school, creating a new dimension of responsibility for teachers and administrators.

### 3.3 IMPACT ON THE AGRICULTURE SECTOR

Because of the central role of agriculture to food and cash-crop production—and rural

livelihoods—the effects of HIV/AIDS on Ministry of Agriculture staff appear at many levels. In the late 1990s, evidence from Kenya indicated that more than half the deaths of Ministry of Agriculture staff were related to AIDS.<sup>9</sup> At roughly the same time, an estimated 16 percent of staff in Malawi's Ministry of Agriculture and Irrigation were living with HIV/AIDS. Three-quarters of the staff reported having lost at least one colleague to AIDS.<sup>10</sup> Even when staff are not directly affected, HIV/AIDS has implications for their work. In Zimbabwe, a study found that agricultural extension workers spent 10 percent of their time attending funerals, a critical social obligation, rather than attending to their work.<sup>11</sup>

A study by the Food and Agriculture Organization of the United Nations synthesized the effects of HIV/AIDS across Africa during the 1990s. Results included the following:

- Up to half of agricultural extension staff time in one Ugandan district was lost due to HIV/AIDS. Staff members were frequently absent from work because they were caring for sick relatives or attending funerals.<sup>12</sup> For the ministry, this made "implementation of certain key activities impossible."<sup>13</sup>
- In Malawi, there were reports of "fisheries field [extension] staff [being] absent to attend funerals half or three-quarters of the working days per month."<sup>14</sup>
- In Namibia, the agriculture ministry found

8. Desai, K. "Projecting the Impact of AIDS on the Education System." Presentation at a seminar sponsored by the World Bank, Accelerating the Education Sector Response to HIV/AIDS in Africa in the Context of EFA, Mombasa, 2002.

9. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). "Factoring HIV/AIDS into the Agricultural Sector in Kenya." Unpublished report, 1999.

10. Bota, S., Malindi, G. and Nyekanyeka, M. "Factoring AIDS into the Agricultural Sector in Malawi." Ministry of Agriculture and Irrigation, presentation at the Durban Toolkit Workshop, 1998.

11. Ncube, N.M. "Impact of HIV/AIDS on Smallholder Agricultural Production in Gweru, Zimbabwe." In: AIDS and African Smallholder Agriculture. Edited by Gladys Mutangadura, Helen Jackson, and Duduzile Mukurazita. SFAIDS, Harare, 1999.

12. Food and Agriculture Organization. *The Effects of HIV/AIDS on Farming Systems in Eastern Africa*. Rome, 1996, p. 73.

13. Ministry of Agriculture, Animal Industry & Fisheries (MAAIF). Response to FAO/UNAIDS Questionnaire on the Impact of HIV/AIDS on MoAs and Their Work. April 2000.

14. Hemrich, G. *HIV/AIDS as a Cross-sectoral Issue for Technical Cooperation: Focus on Agriculture and Rural Development*. GTZ, 1997.



that staff absences to attend funerals disrupted scheduled meetings, training activities, and field demonstration days.<sup>15</sup>

- In Zambia, the absence of a consistent policy and plan to address HIV/AIDS among Ministry of Agriculture staff has been increasingly costly.

### 3.4 IMPACT ON THE UNIFORM SERVICES

Military, police, prison, customs and other uniform services staff are especially at risk for HIV infection (see Case Studies 1 and 2). UNAIDS and other agencies report that in some southern African militaries, HIV infection rates range from 30 percent to 60 percent. In Kenya's military hospital in Nairobi, at least half the patients are PLHA. The deputy chief of the Kenyan general staff said in mid-2003 that HIV/AIDS was resulting in a loss of continuity at the command level. He noted the increased costs for medical care, recruitment, and training for the army, which was losing between 25 and 45 soldiers to HIV/AIDS every month.<sup>16</sup>

Kenya's prison service reported in 2003 that up to 15 staff had died or retired each month as a result of HIV/AIDS. The service noted, without indicating what corrective actions were in place, that warders were recognized as being vulnerable to HIV/AIDS because they lived away from their families.<sup>17</sup> In addition, Ghana's customs and excise officers often serve at posts away from their families, thus increasing their risk for infection.

The police force in one province of Zambia reported that, on average, 50 officers were dying of AIDS each month. In Malawi, 45 percent of police force attrition during 1990–2000 was due to AIDS deaths, rising from 23 percent in 1990, to 49 percent in

1997, and to nearly 58 percent in 2000. The trend parallels the expansion of the epidemic in the country. Losses in middle supervisory ranks were especially notable, and numerous vacancies remained in those categories.

HIV/AIDS is found in the militaries of Asian nations, but to a lesser degree. The Burmese government estimates that 2.5 percent of new military recruits are HIV-positive.<sup>18</sup>

### 3.5 IMPACT ON INDIVIDUAL STAFF AND THEIR FAMILIES

Prolonged HIV/AIDS-related illnesses affect staff in several ways. These can be categorized as:

- Ability to work
- Morale of employees under conditions of stress and overwork
- The need to cope with the costs of treatment and care

The ability to work must be considered on two levels: the on-the-job presence and performance of a staff member who is HIV-infected, and that person's support for his or her family and friends.

As HIV undermines the body's immune system, susceptibility to other illnesses increases. Workers take sick leave to deal with those illnesses or to care for family members who are sick. Also, the ability to carry out job functions may be hindered by HIV/AIDS and related illnesses. Studies in both the public and private sectors show that absenteeism is a major cost to organizations. In turn, staff absences affect the work of others. Attendance at funerals—of family members or work colleagues—is often

15. Ministry of Agriculture, Water and Rural Development (MAWRD). Response to FAO/UNAIDS Questionnaire on the Impact of HIV/AIDS on MoAs and Their Work. May 2000.

16. All Africa News Agency. "AIDS Is Quietly Decimating Africa's Strong People." June 2, 2003.

17. BBC News. "AIDS Burdens Kenya Prison Warders." June 23, 2003.

18. *The Irrawaddy*. "An Interview with Dr Myat Htoo Razak: Facing the Challenge." Vol. 11. No. 4, May 2003.



socially obligatory. These absences have become a significant factor in disrupting work routines.

Colleagues might assume that staff who show signs of prolonged illness are HIV-positive. The stigma, fear, and discrimination associated with AIDS are deeply embedded in society. In Thailand, discrimination against families with an HIV-positive member has resulted in significantly higher household rent and increased likelihood that the infected person will lose his or her job.<sup>19</sup> Many workers fear losing their jobs or the stigma they will face if their HIV status is known. Fear and stigma can cause worker depression and inattention on the job.

Morale is also influenced by difficult work conditions. Poor morale spreads through a workforce, especially if work conditions do not change. In South Africa, health care workers say they are overworked, and because they often fill in for absent colleagues, they perform their work less efficiently and with less attention to detail.

Finally, HIV/AIDS is costly to individuals and families. Many workers will use private health services, at their own expense, rather than public services.

### 3.6 RESPONSES TO DATE

HIV/AIDS services for public sector employees are increasing. Some of these program responses are based on well-considered policies and plans. In Brazil, a free nationwide HIV testing and counseling initiative is available to the general public and government workers. Since the mid-1990s, the Thai government has provided all or most funding for its HIV/AIDS programs, which also cover government employees.

The response by Ugandan ministries is one of the most thorough and coordinated in the world. The government established a coordi-

nating group of focal persons from all ministries and agencies. Members discuss common issues in their workplaces. Government ministries have HIV/AIDS work plans, and all but two have workplace strategies. Most of the programs include staff sensitization, counseling, counseling training and condom distribution. The Ministry of Public Service is reviewing guidelines on human resource policies, the standing orders, and the employee code of conduct.

Responses may be limited to select ministries. Zambia's Ministry of Education has developed an HIV/AIDS Strategic Plan that includes a means to perform a human resources policy audit on a periodic basis. The ministry's efforts include a handbook that helps teachers protect themselves, to work with colleagues living with HIV/AIDS, and to assist students with HIV or who are affected by a parent's illness. Many ministries have adopted a multisectoral philosophy. Zambia's workplace policy, for example, includes promotion and distribution of condoms to teachers and other education staff (see Case Study 3).

In other cases, responses are devised as the need arises. These may include placing condom dispensing machines in the workplace, selecting peer educators to interact with staff, and convening occasional sensitization events. Increasingly, ministries are reviewing options to provide ART to employees.

Malawi has reviewed many of its policies and laws to determine whether they are appropriate given the realities of HIV/AIDS. The review has included the Employment Act, the Labour Relations Act, the Workers Compensation Act, the Occupational Health Safety and Welfare Act, the Wills and Inheritance Act, the Estate Duty Act, and the Taxation Act. The union for Tanzanian health workers has been reviewing national policies related to workers who

19. Kongsin, C., Watts, S. and Jiamton, S. "The Impact of Chronic HIV/AIDS Morbidity on the Economic Well-being of Households: Evidence from Phayao, Thailand." Abstract from 2002 AIDS Conference.

become infected through an industrial accident. Many countries are examining policies that relate to orphaned children and their care, including inheritance and educational assistance.

In 2003, the Government of Burundi directed the insurance company that covers medical and drug costs for government employees to cover 80 percent of ARV drug costs; employees are expected to pay the remaining 20 percent. This likely will increase the premiums charged to the government.

### 3.7 PREPARING AN HIV/AIDS INSTITUTIONAL ASSESSMENT

An HIV/AIDS institutional assessment is one way to gather and analyze information on factors affecting the functioning of a ministry, department, or agency (and its employees) in the context of the epidemic. The assessment can be a snapshot of a situation at a given time or it can provide information for monitoring changes.

An institutional assessment provides the quantitative and qualitative data needed for ministries to make informed decisions about human resource planning, cost management, training needs, and HIV/AIDS programs. The data are most valuable when they are used to show trends—that is, what has happened over a period of several years.

Two concepts are helpful in designing and conducting an HIV/AIDS institutional assessment:

Susceptibility describes features of an organization that make it more or less likely that its workers will contract HIV. For example, expectations or demands that certain male employees spend long periods away from home and family will increase the susceptibility of those employees, and thus the organization, to risky sexual behavior and HIV.

Vulnerability describes aspects of an organization that make it more or less likely that unusual levels of illness or death will negatively affect its operations and performance. For example, when decision-making involves a coordinated process that requires key workers with specific skills or responsibilities, illness or death will severely affect the process.

An institutional assessment consists of the following components, which form a series of linked steps:

- Personnel profiling
- Critical positions analysis
- Assessment of organizational procedures
- Estimate of organizational employee costs
- Employee productivity
- Organizational context

Each step is described below. The questions can be used as a checklist to facilitate the design of an institutional audit.

#### Step 1: Personnel Profiling

##### a) Characteristics of employees

Most ministries have distinct categories for workers.

- How many people are employed in each category? (Where possible, divide this by gender, age and locale [headquarters, province, district, hospital, clinic, etc.])
- How many vacancies exist within each category? Where possible, divide this by gender, age, and locale.
- What level(s) of education and technical and managerial training are required for each category?

- What level(s) of experience are required for each category?
- What is the strategic importance of each category for the effective functioning of the ministry/department/agency?

#### **b) Susceptible groups**

Which employee categories (if any) are most likely to be susceptible to HIV infection? To determine this, use the following questions:

- Are specific employee groups particularly exposed to infection? Examples can include health care workers who treat patients or employees who travel frequently or are away from home for extended periods.
- Why are they exposed?
- What are the gender and age characteristics of the most susceptible groups?
- Can or should the organization do anything to reduce this exposure?

#### **c) HIV/AIDS rates and interventions**

In the absence of data from in-house HIV testing, it can be assumed that HIV prevalence among employees is roughly equivalent to that of the general population.

- Given the known and predicted rates of HIV prevalence, how many people might be expected to become ill or die each year over the next 5/10/15 years in each employment category? A demographer usually can assist in this part of the process. (Note: To evaluate the estimated impact of HIV over time, it is important to understand the progression from HIV to AIDS. In many countries, people who are HIV-positive today are likely to become sick with AIDS or related diseases within 6–10 years. The availability and affordability of ART and effective treatment of opportunistic infections will prolong life.)

- What HIV/AIDS interventions does the ministry have in place? Do these reach all employees? Are the interventions accepted and used by employees?
- Which HIV/AIDS prevention and care interventions are most accepted and used by employees? Which are least accepted and used? What are some reasons employees do or do not accept interventions?

#### **Step 2: Critical Positions Analysis**

- Are there key personnel on whom a service or administrative process depends and who will be particularly difficult to replace? Examples might include people with “institutional memory,” financial planners or training supervisors.
- Are there key personnel (communication, decision-making, training, and supervision) who must be in place for staff to do their jobs effectively?

#### **Step 3: Organizational Procedures**

Formal and informal work procedures and arrangements influence the ways the ministry addresses employee illnesses and deaths, absenteeism, and replacement.

- How easy will it be to replace or retrain staff from within the organization? What is the lead time for training or recruiting replacements for different skill levels or categories?
- Are sufficient people allocated to specific categories of jobs to allow internal upgrading and staff training to fill vacant positions?
- How quickly can promotions be made and approved?
- How long can “acting” positions be held?

- Do personnel procedures permit task-sharing or job-sharing between two or more employees?
- Do personnel procedures permit flexible work schedules for employees who need them?
- Is it possible to train and employ an additional staff member for every critical post (i.e., “shadowing” of key employees)?
- Can internal experience be substituted for academic or skill training in filling vacancies (an important consideration in advancing clerical and lower-level administrative staff into more responsible positions)?
- What recent changes have been made in personnel work procedures? Why were they made? How did managers and workers react?
- Can non-core functions (for example, security and cleaning) be outsourced to the private sector? Some of this is already occurring as ministry functions are reformed.

#### **Step 4: Employee Costs**

The potential or actual liability of an organization will be determined by some or all of the following factors:

##### **a) Staff replacement costs and processes**

- How long does it normally take to fill a vacancy?
- What is the cost of recruiting new people?
- What additional training is normally provided to new hires?
- What is the typical length of time for a new employee to become fully functional and effective?
- What is the length of sick leave permitted before an employee is terminated and replaced?

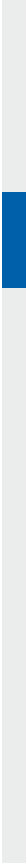
##### **b) Operational costs**

- What is the ministry's cost to provide medical insurance to each employee? (Where possible, differentiate by employee category.)
- What is the ministry's cost to provide funeral and death benefits and other obligations to dependents upon the death of an employee?
- What cost does the ministry incur in employee absenteeism (by day or week)?
- Has the ministry estimated the costs of providing ART to employees (dependents?) living with HIV/AIDS?

#### **Step 5: Employee Productivity**

The quality and quantity of labor provided by employees may be reduced when they are sick or caring for sick dependents.

- How many days of sick leave have employees used over the past quarter or year? (Where possible, differentiate by gender, age, locale, and employee category.)
- Is there evidence (or a sense) that the absence of employees on sick leave has reduced the organization's efficiency or productivity?
- How many compassionate leave days to care for sick relatives or attend funerals have employees used over the past quarter/year? (Where possible, differentiate by gender, age, locale and employee category.)
- How many employees have attended funerals over the past quarter or year?
- Can new equipment be used to replace people who are sick or have died?



#### **Step 6: Organizational Context and Labor Relations**

- Are industrial relations procedures and regulations generally followed when addressing personnel issues? If not, provide examples where practice differs from the procedures.
- What must an organization do for its workers in the way of invalidity benefits?
- Does the organization have a policy or procedure for accommodating changes in work arrangements for employees who are unable to continue their tasks in expected ways?
- Does the organization encourage employees to use HIV/AIDS services located in local communities? Services can include voluntary HIV testing and counseling, STI treatment, home-based care assistance, etc.
- Is there a national or ministry policy on providing ART to employees? Does the policy also cover the employee's dependents?
- Is there a procedure for employees who wish to access ART, if it is available?

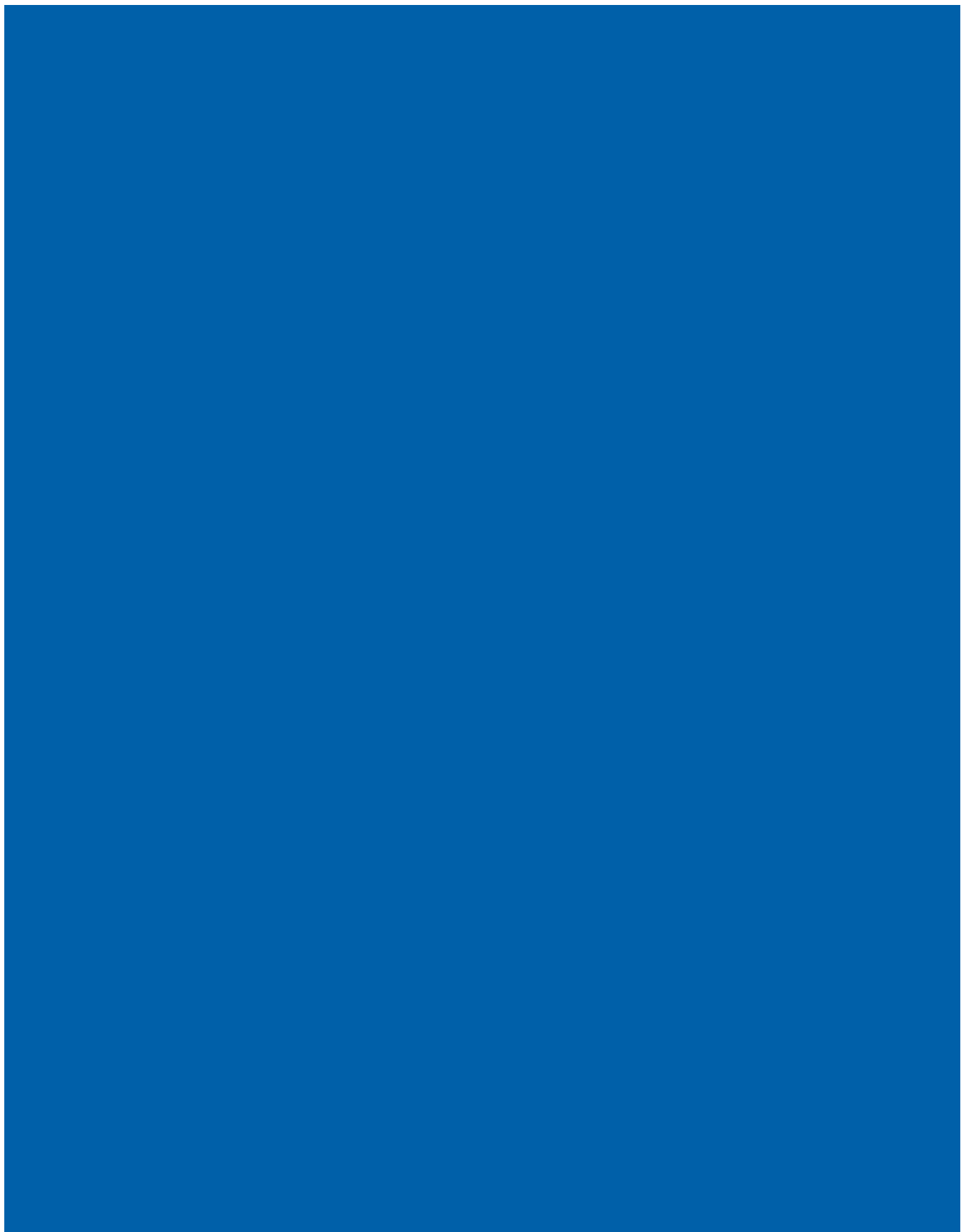
## CHAPTER FOUR

### BUILDING LEADERSHIP WITHIN THE PUBLIC SERVICE



This chapter covers:

- The importance of senior-level leadership and commitment to HIV/AIDS prevention, care and mitigation
- The benefits of assembling an in-house team and advocacy
- The use of focal points to head ministry responses to HIV/AIDS
- Advocacy in the workplace



As a formal, bureaucratic structure with many individual components, the public service has well-established regulations and practices for leadership and decision-making. These practices can be both an opportunity and a constraint in addressing HIV/AIDS. Informed and committed public service leaders can influence employees at all levels. A minister or permanent secretary who encourages employees to take actions that will prevent the spread of HIV will, through words and deeds, set a standard for an entire agency.

Such a leader will ensure that prevention interventions are in place and accessible. He or she will support staff assigned to lead the ministry's responses to the epidemic. He or she will expect, receive, and act on regular reports about how prevention, care, and mitigation initiatives are progressing.

As concern about HIV/AIDS has grown, an increasing number of political, religious, business, and civic leaders are speaking directly about the disease. These public statements are important contributions to overall prevention and anti-stigma efforts. Experience has shown that effective leadership includes the following characteristics:

- Openness on the part of political and management leadership about AIDS, how HIV is transmitted, and what can be done by employees and the ministry to reduce risk
- Support for responsible sexual behavior among employees
- Support for adopting and implementing appropriate policies to address HIV/AIDS-related situations that may arise in the workplace
- Moral, financial and resource support for prevention, care and mitigation programs within the ministry

- A commitment to sustain programs over time.

Public sector leadership in framing effective HIV/AIDS policies and programs provides legitimacy and credibility to efforts to encourage private companies to take HIV/AIDS seriously and to formulate appropriate workplace policies. Public sector policies set standards for other sectors and guide companies and faith groups in developing their own policy guidelines. In responding to HIV/AIDS, the leadership role that most governments claim will be accepted insofar as they develop HIV/AIDS policies and programs for their own workers and their workers' dependents. In turn, government leaders need information, guidance and support from the people with whom they work.

### 4.1 ENHANCING LEADERS' ROLES IN HIV/AIDS

Three situations impinge on public sector leadership. The first occurs when audiences are cynical about a leader's sincerity and commitment, particularly if a leader offers simplistic, paternalistic or repetitious messages about HIV/AIDS. The second occurs when senior leadership remains unconvinced of the importance of addressing AIDS. Increasingly, leaders are taking AIDS seriously, but that has not



always been the case, especially if they know little about it. The third situation that limits full leadership is the reality that changes within large, complex organizations can take a long time to occur. A senior leader within a ministry, for example, may be fully committed to addressing HIV/AIDS, but he or she must convince others in the organization to take effective steps.

These situations exist at various times and in various ways within most national and local civil services. Where they exist, other staff can influence the political and bureaucratic leadership and the internal processes surrounding HIV/AIDS, and reduce the length of time required to bring changes to personnel policies and procedures.

## 4.2 AN HIV/AIDS TEAM

Forming a team to promote HIV/AIDS issues in the workplace has been a critical element in the change process. Teams may be formal or informal; they may be organized to achieve a specific purpose, or their objective may be to address longer-term goals. Team members may be self-selected (i.e., they choose to join the team) or they may be appointed by managers. Especially important members on workplace teams are women affected by HIV/AIDS and PLHA if they identify themselves. For teams to work effectively, members must have the time and responsibility to gather information and formulate options and actions. Where a team is formally organized, supervisors should allow team members time to attend to the team's duties.

Team members addressing HIV/AIDS issues recognize that options must be developed and actions taken more quickly than in normal circumstances. That is, a team response is a way to cut through the bureaucratic structures that normally encompass work and decision-making processes. Another advantage of teams is that they bring together people with diverse

skills. As such, they can offer new ideas for achieving assigned results. In many instances, team members have access to a range of needed and useful information, and to leaders, through formal and informal channels.

Teams can bring information and recommendations to the political and bureaucratic leadership. In some cases, the leadership initially may be unaware of the advocacy team, if the team is informal in its operations. But the nature of advocacy involves providing effective and timely information to decision-makers in forms they can readily use.

In a number of countries, it has become commonplace for political and bureaucratic leaders to include a message about HIV/AIDS in many or all of the public statements they make. After a time, however, these messages may become repetitious, lose relevance for the audience, or include outdated information.

Given the commitment to publicly addressing AIDS issues, leaders can enhance their messages in several ways:

- By including in the statements new information about a ministry policy or implementation plan, new information about changes in HIV prevalence rates, or new information about planned programs.
- By including stories about successful responses to the epidemic, from within the ministry or from the geographic area where the talk is presented.
- By placing a message in the context of meeting with PLHA or caregivers, to show commitment to reducing the stigma and discrimination surrounding the disease.

In addition, those who are in a position to influence leaders can ensure that AIDS issues are included in the agenda of all meetings of a senior decision-maker.

For senior officials to speak in committed and relevant ways, they need relevant and current information, including examples. Someone who is in a position to influence officials can help by providing information such as:

- An in-depth description of one or two aspects of the ministry policy (or planned policy) on HIV/AIDS. Other aspects of the policy can be discussed during subsequent meetings. The leader must be briefed, verbally or in writing, on the intent of the policy and how it is being implemented.
- Examples of interesting and successful responses by ministry employees.
- Changes in HIV prevalence or impact data that are likely to affect the ministry. New studies, both national and local, often appear on a regular basis. Findings can be synthesized for delivery to senior officials.
- During budget deliberations, information on the cost of mounting and sustaining HIV/AIDS activities within a ministry.
- An analysis of the effects of HIV/AIDS on one or more aspects of staffing, such as changes over time in levels of absenteeism, staff deaths or the costs of recruiting new staff. This information does not have to be definitive; it can be indicative of a given situation or changes affecting the ministry.

In situations in which leaders remain unconvinced that HIV/AIDS is a real or potential problem for the ministry, several internal advocacy techniques have been used. One is to keep records related to one or more aspects of HIV/AIDS. Doctors at hospitals and clinics of quasi-public organizations have been known to maintain statistics on cases of HIV/AIDS, STI, tuberculosis, and other related illnesses in anticipation of using that information with senior management. Human resource officers and departmental supervisors can keep track of time lost to absenteeism.

Where national or ministry AIDS policies exist, these can provide a framework within which to raise related program, human resource, and policy issues. Likewise, the impact of HIV/AIDS can be used to indicate how the disease is impinging on labor laws and regulations, standing orders, and other legal and process standards. Suggestions can be put forward for changing personnel issues to draw the attention of a senior leader. Beginning with a proposal for a modest change, such as including HIV/AIDS prevention in new staff briefings, may provide the opening for discussions on more difficult or complex issues.

A group of internal advocates, even if they are informally organized, is more powerful than a single individual advocate. People can share information and strategies, and will have access to different channels for reaching senior officials. People can meet during lunch breaks or communicate via e-mail. Ministries or agencies that have appointed an HIV/AIDS focal person or unit have a formal mechanism through which to channel information and ideas.

Finding opportunities to present information and arguments to enhance the HIV/AIDS response may be difficult. One can ask that a topic be placed on the agenda of staff meetings, included as part of budget planning processes, or considered during supervisory meetings. In some cases, organizations outside the ministry have been asked to approach the ministry to make a presentation about the effects of HIV/AIDS or related topic. Sometimes, outside organizations will receive greater attention than internal advocates will.

#### 4.3 MINISTRY HIV/AIDS FOCAL POINTS

Numerous governments have adopted the idea of an organizational HIV/AIDS focal point. The focal point may be an individual or a unit within a ministry. The focal point is usually assigned the responsibility of day-to-day coordination of

a ministry's HIV/AIDS program, at the headquarters or within a field office. The focal point may also be responsible for peer interaction, condom distribution, counseling, distributing information on community resources, and monitoring ministry activities. In some

#### **SAMPLE TERMS OF REFERENCE OF AN HIV/AIDS FOCAL POINT**

A ministry HIV/AIDS focal point person will have important responsibilities. As senior management creates or expands the role of an HIV/AIDS focal point, the following criteria will enhance the effectiveness of the person.

The HIV/AIDS focal point will be a full-time employee:

- Who is interested in committed to HIV/AIDS issues
- Who is familiar with HIV/AIDS issues, including prevention and care
- Who is familiar with internal personnel policies and procedures
- Who is recognized for leadership ability, including interpersonal and facilitation skills

The HIV/AIDS focal point position should perform the assignment on a full-time basis. If that is not feasible, the person(s) should be relieved of other duties equivalent to the portion of time required to serve as a focal point. Also, the focal point person's work should be included in his or her performance evaluation. The focal point should receive a public and clear mandate from senior management.

The focal point will be accountable to a senior manager and will have regular access to the manager. The focal point should provide monthly reports (written or oral) to her or his HIV/AIDS supervisor. The focal point should be given the responsibility and flexibility to outline comprehensive responses to HIV/AIDS for the ministry.

cases, a focal point person may monitor HIV/AIDS activities of constituents that fall within the ministry's purview, but not within the ministry itself—an incomplete and inappropriate role for a focal point as described here. An example would be a Ministry of Labor focal point person who monitors the HIV/AIDS policies of unions but not of the ministry's own workforce.

Some constraints identified by HIV/AIDS focal points include the following:

- The expectation that existing job responsibilities will continue unchanged while new AIDS responsibilities are assumed.
- Irregular access to senior decision-makers
- Lack of budget
- Lack of opportunities to keep up with current issues relevant to AIDS and the workplace
- Extensive amounts of time devoted to problems and issues raised by individuals

In creating or expanding the position of an HIV/AIDS focal point person, knowing what has failed elsewhere will be helpful.

#### **4.4 ADVOCACY WITHIN THE WORKPLACE**

The complexity of responding to HIV/AIDS in the government workforce can lead to inaction. Concerned individuals or small groups within ministries or agencies who have seen evidence of the effects of HIV/AIDS have been able to initiate responses. Medical officers, human resource managers, HIV/AIDS focal point persons, and worker representatives are likely to be aware of the presence and impact of HIV among employees before senior managers and ministers or directors. For example, a medical officer may see an increasing number of tuberculosis cases or the human resources manager may note increased long-term absenteeism. Many countries now have

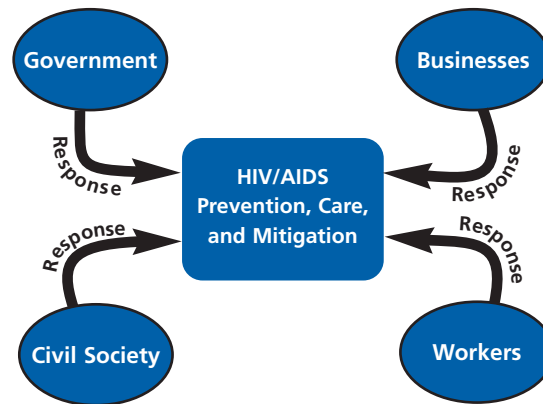
formal structures to address HIV/AIDS. But in some cases the processes have not been implemented; in other cases, implementation has been slow. To demonstrate the urgency of developing and implementing effective workplace responses, internal advocacy may be necessary to inform and persuade some senior management.

Each ministry and agency has its own internal communication and decision-making processes. Many ministries and units of ministries now have focal point persons. Some focal points act as peer educators and counselors. Others are responsible for drafting policy statements and overseeing implementation of workplace HIV/AIDS activities. Others are the minister's or permanent secretary's representative with authority to act on their behalf. Whatever level of responsibility and power that focal point people may hold, they are key individuals around which effective internal advocacy can occur. The information in this guide on the economic impact of HIV/AIDS; the benefits to be derived from effective prevention, care, and mitigation programs; and experiences in other countries can be adapted to present a case for developing or revising an HIV/AIDS program in the workplace.

Users of this guide are encouraged to use the information that best meets their needs to persuade senior management and senior employee representatives to adopt an HIV/AIDS workplace program. Experiences indicate that decision-makers often ask the following types of questions:

- What is the extent (prevalence) of HIV infection within the workforce?

#### Multiple Response to HIV/AIDS



- How is HIV affecting worker productivity?
- Are there changes in worker productivity, and if so, how is work efficiency affected?
- What are the known and likely future costs of HIV/AIDS to the ministry?
- What will it cost to mount or expand a workplace HIV/AIDS prevention, care/treatment, and mitigation program?
- Are we doing enough already to see positive results?

Unions and worker representatives often ask the following questions about HIV/AIDS workplace programs:

- What is the ministry's position on ART? Will employees have access to ART if they need it?
- Will the government respect the privacy of workers who seek HIV/AIDS information or services?
- How will supervisors and the organization as a whole minimize and eliminate HIV/AIDS-

related discrimination and stigma that some employees may face?

- What changes in personnel procedures can be put in place to strengthen prevention or to assist infected and affected employees?

Anticipating management and union questions and concerns will help collect and present information that meets their needs. Charts, bullet points and clear recommendations for action are powerful components of an effective presentation to inform and influence actions on HIV/AIDS. Also, informal talks with concerned managers and employee representatives can help build an internal constituency for further action.

Workers have a central role to play in shaping and sustaining public sector HIV/AIDS work-

place efforts. Unions and other worker representatives can ensure that prevention and care are on the agenda during discussions and negotiations. They can use their collective influence to raise issues expressed by members. In other cases, government workers have taken a lead role in expanding prevention efforts into their work and home communities, thus representing government in a favorable light. Some of the most effective community outreach programs have involved government employees who have, often as volunteers, promoted HIV/AIDS prevention in the communities where they live, worship, and socialize.

## CHAPTER FIVE

### WORKPLACE HIV/AIDS POLICIES



This chapter covers:

- The value of an HIV/AIDS policy for public sector workforces
- Elements of an effective HIV/AIDS policy
- An outline for drafting an HIV/AIDS policy
- Ways to disseminate and implement the HIV/AIDS policy



Many countries now have HIV/AIDS policies and, increasingly, countries are also adopting HIV/AIDS policies for the workplace; in some countries, specific ministries have designed AIDS policies for their workforces. The rationale for a ministry developing an AIDS workplace policy is to provide its employees with clear statements on expectations and responsibilities. Such policies also provide supervisors and managers with guidance to address AIDS-related issues.

### 5.1 THE VALUE OF HIV/AIDS POLICIES

An HIV/AIDS policy defines an organization's position and practices for preventing HIV transmission and handling situations affecting employees living with HIV/AIDS. The policy may describe particular actions that the ministry will take to mitigate the effect of HIV/AIDS on its efficiency, such as changes in job responsibilities for all or some employees. The policy guides supervisors who manage the day-to-day issues and problems that arise in the workplace. The policy also informs employees about their responsibilities, rights, and expected behavior while on the job.

HIV/AIDS policies are important features of workplace responses to the epidemic. They provide a framework for guiding changes in personnel procedures, managing budgets and costs, and strengthening HIV/AIDS prevention and care programs.

An HIV/AIDS policy:

- Sets a foundation for HIV/AIDS prevention, care, and treatment programs
- Offers a framework for consistent practices within a ministry
- Expresses the standards of behavior expected of all employees

- Informs all employees what kind of assistance is available and where they can access it
- Guides supervisors and managers on managing HIV/AIDS in their work groups
- Assures consistency with relevant local and national laws and statutes

But, like any policy, an HIV/AIDS policy is only as valuable as the commitment to work within its scope. If drafting a workplace policy is simply a pro forma exercise whose details will be later forgotten or ignored, then developing a policy is hardly worth the time and effort.

### 5.2 WRITTEN POLICIES AND PERSONNEL PRACTICES

Almost all government employees are subject to written personnel regulations and practices—usually known as standing orders. Many of these regulations are deeply entrenched in bureaucratic structures—they are part of standard practice in the daily function of public servants' duties. In other instances, day-to-day operations have probably developed that may be as accepted as the personnel regulations, though they have not been codified. For example, it may be policy that employees can take off two days a year to attend funerals, but the policy is often ignored by other employees and



supervisors. Many government departments address chronic deviation from the standing orders by ignoring the situations or addressing them on a case-by-case basis. This procedure has usually offered a humane response to employees' needs. Employees are usually given reasonable flexibility and assurances of continued benefits.

But as employee absenteeism, illness, and death have increased, civil service managers have experienced a greater need for policy guidance. Ministries are seeking ways to manage declining morale as workers try to fill in for coworkers who experience prolonged absences. And as ART becomes affordable, many ministry finance officers are wondering how the costs will be absorbed and managed by already stretched budgets.

Policy guidance and revisions in personnel procedures will help address the variety of issues

#### **POLICY OR PREVENTION PROGRAM: WHICH COMES FIRST?**

There are no specific rules about the sequence—first an HIV/AIDS policy or first a prevention program. In fact, both a policy and prevention program are necessary and will evolve over time, as conditions change.

It can take more than a year for workplace policies—and subsequent changes in work-force procedures—to be formulated and approved. In such situations, it is best to move ahead with implementation of the prevention program before the policy is in place. Practical experience in implementing programs can, in turn, inform the drafting of realistic policies.

Where prevention programs already exist, it is not necessary to put them on hold until a policy is developed. But people should use their experiences in HIV/AIDS prevention in the workplace to inform subsequent policy decisions.

arising from HIV/AIDS. Workplace HIV/AIDS policies will provide clarity and certainty about a subject many people find confusing and uncertain.

### **5.3 BASIC PRINCIPLES**

Successful HIV/AIDS policies developed by governments, businesses, and international organizations share a number of basic principles. These principles are recommended by international organizations such as the International Labour Organization (ILO). In 2001, ILO issued a new "Code of Practice" on HIV/AIDS, based on extensive dialogue with businesses, worker organizations, and governments around the world.

The ILO Code of Practice and other basic guidelines offer a sound basis for shaping a workplace HIV/AIDS policy. The following key principles are adapted from the Code of Practice and experiences of several governments.

#### **1. Recognition of HIV/AIDS as a workplace issue**

HIV/AIDS is a workplace issue because it threatens productivity and the welfare of all employees and their families. The workplace, being part of the national response, has a role to play in the wider struggle to limit the spread and effects of the epidemic.

#### **2. Nondiscrimination**

Discrimination against workers on the basis of real or perceived HIV status must be actively discouraged. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention, care and treatment, and mitigation. Stigmatization can easily lead to disruptions in the workplace.

#### **3. Gender equality**

Discrimination against women and the sexual exploitation of women promotes the spread of HIV. Also, women are more likely to become infected and are more often adversely affected by HIV/AIDS than men due to biological, socio-

cultural, and economic reasons. Proactive efforts by government offices to prevent gender discrimination and sexual coercion and abuse will greatly aid prevention efforts.

#### **4. Healthy work environment**

The work environment should be healthy and safe, in line with national regulations and negotiated agreements, to reduce the risk of on-the-job transmission of HIV. A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health. Universal precautions are stressed to provide practical guidance for protecting workers who may be exposed to blood on a day-to-day basis.

#### **5. Social dialogue**

Implementing an HIV/AIDS policy and program successfully requires cooperation and trust between workers and their representatives and government. The involvement and support of both management and workers is essential for effective HIV/AIDS prevention and care policies and programs. Ongoing dialogue at all levels widens the discourse around HIV/AIDS issues and improves prevention, care, and mitigation.

#### **6. Screening for purposes of exclusion from employment or work processes**

Mandatory HIV/AIDS screening is unnecessary and inappropriate for job applicants and employed persons. Employees and their dependents should be encouraged to voluntarily obtain a confidential HIV test and pretest and post-test counseling.

#### **7. Confidentiality**

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should coworkers be obliged to reveal such personal information about themselves or fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality.

Breaches of confidentiality erodes employee morale, can disrupt production, and can lead to legal action.

#### **8. Continuation of employment relationship**

HIV infection is not a cause for termination of employment. As with many chronic conditions, persons with HIV-related illnesses should be able to work for as long as they are medically fit to do so in available, appropriate work, which can be many years. As ART becomes more commonly available, continuation of work will become less an issue.

#### **9. Prevention**

HIV infection is preventable. Prevention can be achieved through various strategies that are appropriately targeted to national conditions and that are culturally sensitive. Prevention can be furthered through changes in behavior, knowledge and treatment, as well as by creating a nondiscriminatory work environment. Unions and business managers are in a unique position to promote effective prevention efforts, including changing attitudes and behaviors by providing information and education, setting noncoercive sexual standards and addressing socioeconomic factors that increase risk for HIV transmission.

#### **10. Communication and leadership**

Employers, unions, and other worker representatives must communicate the policy to employees in simple, clear, and unambiguous terms and continue to demonstrate their support for HIV/AIDS prevention and care efforts. Communication of clear messages will reinforce established business practice, assure consistent implementation of the policy, and reinforce low-risk worker (including sexual) behaviors.

#### **11. Care and support**

Solidarity, care, and support for infected individuals and their family members should guide the response to HIV/AIDS in the world of work. All workers, including workers with

HIV, are entitled to access to affordable health services, whether through the public health system or national insurance schemes, or through private facilities. There should be no discrimination against HIV-infected employees and their dependants in access to and receipt of benefits from social security programs and occupational schemes. The increasing availability of ART requires government ministries to set clear guidelines on who will have access to the therapy and the requirements for gaining access to it.

Another point can be added: Ensuring access to ART for pregnant women and for PLHA. The growing commitment of governments to assure the provision of ARV drugs, the downward trend in drug prices, the growing simplicity of the treatment regimens, and the increases in international agency support for funding drug programs all bring ART within reach of a growing number of people.

These basic principles can be adapted and made specific to the HIV/AIDS policies of each country, ministry, and worker organization.

#### 5.4 THE NATURE OF A WORKPLACE POLICY

HIV/AIDS workplace policies can be several paragraphs or pages in length. The policy will incorporate a range of provisions that set out the ministry's thinking and positions on the many issues surrounding HIV/AIDS.

A longer policy has the advantage of addressing questions and concerns that may arise over time among supervisors and employees. Also, a more detailed policy provides guidance to assist supervisors and managers who will be managing HIV-infected employees or situations caused by the disease.

Given the complexity of HIV/AIDS within the workplace context, the misinformation that continues to exist, and the potential for discrimination and misunderstanding, this guide recommends that public sector ministries and

agencies develop a policy that is as thorough as possible for all circumstances.

#### 5.5 PREPARING TO DEVELOP AN HIV/AIDS POLICY

Formulating or revising an HIV/AIDS policy can be a lengthy process. Clarifying the following points can make decisions easier and speed up the process.

- Is ministry leadership committed to developing or revising the HIV/AIDS policy?
- Has a team been appointed or selected to direct the policy development process?
- Is the team representative of the employee categories in the unit (including women and, if known, PLHA)?
- Have existing policies been reviewed for their relevance to HIV/AIDS issues?
- Have policies from other parts of the government or from private sector companies been reviewed for ideas that can guide this policy?

#### 5.6 OUTLINE FOR DRAFTING AN HIV/AIDS POLICY

The following points can be used in preparing an HIV/AIDS policy. The points can be considered paragraphs or provisions in the policy.

##### Introduction

- \_\_\_ The reason(s) why an HIV/AIDS policy is considered important for the organization.
- \_\_\_ Who the policy applies to (e.g., some or all employees, or different provisions for different categories of employees).
- \_\_\_ Policy compliance with existing or draft national and trade agreements.
- \_\_\_ How the policy will be implemented.

### General Considerations

- \_\_\_ A statement on how the HIV/AIDS policy relates to the mission and function of the ministry/agency.
- \_\_\_ A statement accompanying changes or planned changes in personnel procedures and regulations.

### Elements Relating to Employment Criteria

- \_\_\_ A statement that applicants and employees will not be screened for HIV as a condition of continued employment or promotion.
- \_\_\_ If there are circumstances in which an employee would be asked to take an HIV test,<sup>20</sup> the policy spells these out in detail and also provides:
  - An explanation of the reasons why a request would be made for an HIV test
  - A statement on whether the employer or the employee will be responsible for paying for an HIV test
  - A statement that pretest and post-test counseling will be provided to any employee asked to take an HIV test or who requests an HIV test
  - A statement on the ministry's response if an employee refuses to be tested
  - A statement on the ministry's intent to keep all medical information confidential, including results of an HIV test
  - A statement of ministry's intent toward employees who, if required to be tested, are found to be HIV-infected
  - A statement on the appeal, arbitration, and resolution options for employees who refuse to be tested for HIV or who, if tested, are HIV-positive

- A statement on the ministry's position toward insurance companies that may require an HIV test for different forms of coverage

- \_\_\_ A statement about the willingness to make accommodations (such as less rigorous work, a different work environment) for employees who request them because of HIV infection.
- \_\_\_ A provision to maintain and enforce legal, acceptable, and recognized occupational safety precautions to minimize worker risk of exposure to HIV infection.
- \_\_\_ A provision relating to the privacy of employee personnel records, including medical records.
- \_\_\_ A statement prohibiting stigma and discrimination against employees who are or who are suspected of being HIV-infected.

### Elements Related to Benefits and Treatment for Employees Infected with and Affected by HIV

HIV/AIDS-related benefits are likely to be an extension of existing benefit provisions. As part of the overall prevention program, an HIV policy can explicitly refer to support for STI treatment. As implied in the previous section of this checklist, workers with HIV/AIDS will be entitled to the same type, level, and form of benefits as other employees with serious illnesses.

A clear statement is needed on the ministry's policy regarding access to ART. Among the issues to consider are:

- \_\_\_ When would therapy normally begin?  
What about continuity in usage, medical monitoring, and related costs?
- \_\_\_ Will the ministry pay all or a portion of ART costs for employees who may require it?

20. The ILO and most other agencies working on HIV/AIDS strongly recommend against HIV testing of employees and applicants. Required testing can easily lead to discrimination, will contribute to employee tensions and suspicions, cannot guarantee that a person will avoid future infection, and often runs counter to existing national policies and labor laws.

- \_\_\_ If the ministry will not pay for a portion or any of the ART, will it assist employees with information, referrals, or both to find affordable treatment?
- \_\_\_ Will the ministry make arrangements so that all or some employees have access to ART?
- \_\_\_ What medical and administrative procedures should an employee follow to gain access to ART?
- \_\_\_ What will be employees' responsibilities if they have access to ART?
- \_\_\_ Will postexposure prophylaxis be provided for workers potentially infected while on the job?

**Other benefits provisions may include:**

- \_\_\_ Statements on employer and employee contributions to health and medical insurance, life and disability insurance, workers' compensation, social security, and other retirement benefits.
- \_\_\_ Statements on provision of leave, including compassionate leave (for caregiving, funerals) and sick leave. The policy must recognize that women usually are the primary caregivers for sick family members and may require different sick and compassionate leave provisions than men.
- \_\_\_ Statements on provision of death benefits for beneficiaries.
- \_\_\_ Statements on types of medical and inheritance benefits, assistance, and coverage for dependents, if applicable.
- \_\_\_ A statement on provision of or support for counseling and related social and psychological support services for HIV-infected and affected employees (and dependents).
- \_\_\_ A statement that the ministry recognizes the importance of peer support groups and permits such groups to be formed and

to meet on ministry property (during or outside of working hours).

- \_\_\_ A statement about legal support services available in-house or by referral. Legal advice can help safeguard dependents through preparation of wills, transfer of property, and leveraging of public services.

**Elements Related to Workplace Prevention**

- \_\_\_ A statement that HIV/AIDS prevention is the responsibility of all employees, including senior management and supervisors
- \_\_\_ A statement on the leadership role of managers and worker representatives, both within the organization and the wider community, in addressing HIV/AIDS
- \_\_\_ A statement emphasizing the importance of responsible sexual behavior among employees
- \_\_\_ A statement referring to ministry and union responsibilities for reinforcing responsible and acceptable sexual behaviors
- \_\_\_ A statement on ministry and union responsibilities to provide all employees with timely, accurate, clear, and adequate information about HIV prevention, community support services, treatment options, and changes in ministry prevention activities
- \_\_\_ A description of the HIV prevention components that will be available to employees; recommended components include easy and regular access to male and female condoms, access to STI diagnosis and treatment, access to a range of services to prevent or reduce harm related to drug misuse, training of peer educators who will be accessible to employees, and information about prevention and care

services in the community

- \_\_\_ A statement on preventing on-the-job accidents and adopting universal precautions to prevent HIV infections in the workplace; a subsection outlining procedures for a worker to receive prophylactic treatment following an on-the-job accident that puts the worker at risk for HIV

#### **Elements Relating to Mitigating the Impact of HIV/AIDS**

There are two levels of mitigation. The first is reducing the effects of HIV/AIDS and related illnesses on individual employees and their dependents. Aspects of this should be described in the section of the policy that discusses benefits. The second level of mitigation explains how the ministry or agency will address prolonged employee absenteeism and loss of staff.

The following factors related to mitigation may be included in a workplace policy.

- \_\_\_ A statement on sick and compassionate leave; a special provision for women, often the primary caregivers in a family, would be appropriate
- \_\_\_ A statement on procedures that assist managers to temporarily fill vacant posts, prior to full recruitment
- \_\_\_ A statement on how human resources officers/departments will process medical retirements
- \_\_\_ A statement on how the ministry expects to cover ART expenses for staff living with HIV/AIDS

Many aspects of care, treatment and mitigation are likely to be addressed in public service workplace procedures (see additional remarks in Chapter 6).


### **5.7 DISSEMINATION AND IMPLEMENTATION OF THE POLICY**

Because of the confusion and emotional stresses associated with AIDS, a policy that addresses some of those concerns is useful only if it is widely disseminated to employees and put into practice. Placing a written policy on a bulletin board is an insufficient way to disseminate the policy.

The policy must be disseminated to all senior managers, the Cabinet and civil service bodies, to union/worker representatives, to human resources or personnel offices, to clinic employees, to supervisors, and to all employees. It is likely that people in these groups will want some explanation of the rationale for the policy and clarification of certain clauses. Thus, a process for introducing the HIV/AIDS policy will be useful. One person or a small team from senior management or the human resources department can introduce the policy and its components to staff members during regular meetings or specially organized get-togethers.

Supervisors are likely to need more than a basic introduction to the policy, because they face the day-to-day implications of the policy (for example, how to respond to an employee who wants time off to care for a sick relative or an employee who raises suspicion about possible HIV infection of a coworker). One or more training sessions for supervisors are entirely appropriate.

The job of supervisors will be easier when all employees are aware of the workplace HIV/AIDS policy and its details. Depending on its length, the policy can be distributed to employees in whole or in segments. It can be posted in public areas. Employee newsletters can include all or portions of the policy, along with explanations of various clauses. It can be included in information packets received by new employees.



There is a tendency for people to forget the details of an HIV/AIDS policy. Occasional reminders—during meetings, or in a newsletter—will further reinforce in people’s minds the ministry’s commitment to HIV/AIDS prevention, care, and treatment.

Implementing the HIV/AIDS policy will occur as it is applied to situations that arise among employees, as supervisors and managers become involved in addressing those situations, and as the ministry puts in place its HIV/AIDS program. The value of the policy is that it guides decision-making in difficult situations. If the policy remains a paper exercise, neither implemented nor enforced, it will not

address situations that arise. As one Permanent Secretary in Africa said, “AIDS is not going away for some years; we deal with it almost every day on the job.”

Finally, knowledge and experience about HIV/AIDS and the costs of prevention and care change over time. Thus, an effective policy will be amended to keep pace with those changes. For example, annual review of the policy by a team from the human resources department, the medical office, and by labor representatives can identify gaps and suggest changes in light of current HIV/AIDS realities and the personnel situation.



## CHAPTER SIX

### WORKPLACE HIV/AIDS PREVENTION AND CARE PROGRAMS



This chapter covers:

- Guidelines for creating or expanding a comprehensive workplace HIV/AIDS prevention program
- Elements of a comprehensive workplace program for PLHA
- Checklists for designing or expanding prevention and care programs





**Prevention and care programs seek to inform and** update employees on HIV/AIDS, promote behavior changes to reduce the spread of HIV, provide services to reinforce behavior changes, and offer services to cope with HIV infection. Effective HIV prevention interventions are not one-time or irregularly held events. Rather, prevention builds on a variety of ongoing coordinated activities and services.

The prevention program is a key component of an organization's response to HIV/AIDS. To help employees stay active and productive, even if they are living with HIV/AIDS, care and treatment programs also are essential for the workplace. These prevention, care and treatment activities will, in turn, be guided and sustained by well-designed policies, as discussed in Chapter 5.

HIV/AIDS affects all employees and their dependents. Thus, prevention and care efforts must be targeted toward and available to employees at all levels and all sites. Prevention for dependents is another way to protect employees. Likewise, care and treatment for all members of a family can prevent the spread of communicable diseases linked to HIV/AIDS, such as tuberculosis.

This chapter outlines the core components of a comprehensive workplace HIV/AIDS prevention and care program. The details will vary within each country, and likely within each ministry, depending in part on the size of the workforce, the nature of the risk factors facing employees, and the ability to coordinate activities with other agencies. A checklist for planning or expanding a workplace HIV/AIDS prevention and care program appears at the end of this chapter.

### 6.1 CHANGING THE ENVIRONMENT THAT FACILITATES HIV/AIDS

As discussed in Chapter 2, the risk for HIV infection is influenced by a variety of social and economic factors that extend beyond individual behavior. Some of these factors derive from the way governments and ministries conduct their public functions—such as requiring frequent travel beyond an employee's home or transfers to posts where housing for dependents is unavailable. Public sector agencies in Ghana have identified environmental factors that contribute to HIV/AIDS risk for employees, such as the relative wealth of public servants vis-à-vis the people they serve and live near. Identifying environmental factors is a first step that must be followed with changes that effectively address those factors.

Changing these environmental factors can reduce the risk for HIV transmission among employees and others. Leaders in public service should consider providing their employees with benefits such as these:

- Adequate housing for families, especially in remote locales
- Condoms, particularly to employees who travel frequently

- Clear messages to prevent sexual harassment and sexual coercion, which will lead to responsible and safe sexual behaviors
- Learning opportunities that allow both women and men to avoid risky sexual situations
- Better opportunities for women to advance in the service

## 6.2 BEHAVIOR CHANGE, INCLUDING RESPONSIBLE EMPLOYEE SEXUAL BEHAVIORS

Many organizations assume that providing HIV/AIDS information to employees is sufficient. But experience has shown that it is not enough to simply inform people about HIV/AIDS, how HIV is transmitted, and how infection can be prevented. HIV/AIDS awareness is just a first step in a sustained program to motivate changes in employee behavior to reduce the spread of HIV. An organization's formal and informal behavior change activities are the foundation for other aspects of the prevention program (see Annex 2).

Behavior change communication (BCC) incorporates a range of methods, messages and topics to inform and influence employee attitudes and behaviors around HIV/AIDS. BCC programs provide employees with the means to assess their risk for HIV infection, promote behaviors to reduce their risk (including condom use and use of HIV counseling and testing services), and support the reduction of stigma and discrimination surrounding the disease.

BCC also includes information on new findings related to prevention and care (for example, on the importance of STI and tuberculosis treatment) and how to find and use services offered by the ministry or agency and in the community. Some BCC messages and materials can be targeted to the most likely users, such as supervisors or worker safety representatives. Changes in ministry or agency policy should be

part of the BCC program, because they are part of the overall information supporting behavioral responses to HIV/AIDS.

Before people can reduce their risk and vulnerability to HIV, they must understand the urgency of the epidemic. They must be given basic facts about HIV/AIDS, taught a set of protective skills, and offered access to appropriate services and products. They must also perceive their environment to be supportive of changing or maintaining safe behaviors. Thus, effective prevention, care, and treatment programs comprise linked activities. Also, particular communication skills are required for developing an effective BCC program. It will be useful to consult with national HIV/AIDS commissions or programs to identify outside organizations that can assist in BCC program design and development.

Core issues to convey through HIV/AIDS BCC programs could include:

- How to handle HIV/AIDS-related problems or employee concerns
- How HIV is and is not transmitted, including via injection drug use and the use of unsterilized needles
- How STIs are prevented and treated
- How to respond to a coworker with HIV/AIDS
- How to assess personal risk and formulate behavior change plans
- Where to find help and additional information
- Statements about acceptable sexual behavior on and off the job

### Acceptable Sexual Behavior

Employees who work in remote areas (such as teachers and agriculture extension agents), who travel frequently (such as drivers), or

who are on temporary assignment away from home (such as customs officials) are at increased risk for HIV infection. Within the ministry or agency policy and its HIV/AIDS prevention program, some discussion is needed about the sexual attitudes and behaviors of employees, especially men.

Discussing sexual behavior is sensitive for all concerned. Extensive research has shown that sexual coercion, intimidation, and harassment of women by men is common. Sexual coercion takes various forms, including violence. Just as common is the use of financial and material inducements to gain sexual favors and advantages from women.

It is essential that managers and employee representatives set out standards of sexual conduct in the workplace. This is not to suggest that the ministry or agency defines appropriate social or sexual partners. Rather, it involves statements that reinforce HIV/AIDS prevention, including discouraging sexual coercion and sexual harassment. Such statements promote:

- Avoiding sexual harassment or coercion, both on and off the job
- Avoiding the use of material or monetary inducements to gain sexual favors
- Avoiding sexual relations with adolescents
- Condom use with sex workers and casual partners.

A national workplace sexual harassment policy implemented in Botswana is a model for other workplaces (see Annex 1).

#### **Peer Educators**

HIV/AIDS education can be carried out by trained health professionals and educators (e.g., medical clinic staff) or by employee peer educators.

Peers are people in the workplace similar to each other in age, background, job roles,

experience, and interests. People are more likely to listen to and follow advice from their peers. Peer educators speak the language of their coworkers and thus have credibility. Peers also have greater influence on each other than nonpeers, and are better able to lend credibility to messages of behavior change. With specific training and support, peer educators (workers) can effectively carry out a range of HIV/AIDS education and other prevention activities with their coworkers.

Peer educators communicate important issues to employees; lead large group meetings; and distribute pamphlets, brochures, and condoms. With training, peer educators also can lead support groups with coworkers. Health-related NGOs can assist in training and providing ongoing support to peer educators.

#### **Peer Education by Management/Worker Representative**

Senior officers of management and unions have opportunities to work with their peers to promote HIV/AIDS prevention. This can happen in the workplace by including HIV/AIDS issues on the agendas of management meetings. HIV/AIDS in the workplace is a logical topic for management-union discussions and negotiations. Many senior leaders feel HIV risks and concerns do not apply to them. But surveys have found that staff at all levels of an organization can become HIV-infected. And protection and care for everyone in the workforce is one of the most important management issues that applies to all government offices.

#### **Education Materials**

The best workplace prevention programs will use a variety of complementary educational activities. This includes lectures, discussions or small group activities, and materials such as posters, brochures, and pamphlets. These materials overlap, strengthening the basic HIV prevention message.

Many types of HIV prevention education materials are available, so it is not necessary for a ministry or agency to prepare many new materials. The national AIDS council, commission, or control program and NGOs working on HIV/AIDS usually have written materials already prepared that can be used in the workplace. At the same time, it is important to review written materials to assure they are appropriate for specific worker groups, relate to the workplace, and convey messages that are credible to workers.

### Support Groups

Employees living with HIV/AIDS or who have a dependent or close friend with HIV are likely to find support groups an important psychological boost. Public service organizations can encourage staff to form or join support groups, either in the workplace or in the community. In several private sector firms, peer support groups have been an important feature for infected and affected employees. These groups provide some financial and much emotional support to coworkers who are living with HIV/AIDS or who have relatives living with HIV/AIDS.

### Dealing with Stigma

People who are HIV-infected or related to someone who is infected often experience a hostile reaction from relatives, coworkers, and friends. A workplace that does not tolerate discrimination against employees and openly supports HIV/AIDS prevention and care efforts will help reduce stigma surrounding the disease. The support groups described above have contributed to a fuller understanding of HIV/AIDS among all employees. In turn, stigma associated with HIV/AIDS has declined.

## 6.3 CONDOM DISTRIBUTION

An important component of workplace prevention programs is distributing condoms to

men and women. Regular and correct condom use is essential in preventing HIV and STIs. A major focus of worker education and prevention sessions is likely to be on the importance of regular and proper condom use.

Unless the ministry or agency is certain that condoms are readily, reliably and affordably available in the surrounding community, the organization will probably want to provide employees with condoms. In fact, many ministries already distribute condoms as part of family planning efforts and HIV/STI prevention and management programs.

The female condom is relatively new but has found ready acceptance among many women. It provides women with greater control for disease protection. The female condom is more expensive than the male condom. It is reasonable for the public service to subsidize the cost of female condoms.

Some employees and their partners argue that condoms should not be distributed in the workplace. They argue, in part, that an employee's private sexual life takes place away from work. This is true, but it is also true that employees' private lives affect their work. Distributing condoms to employees supports and reinforces HIV education and prevention activities. Almost all organizations that permit condom distribution have found favorable responses from employees, both men and women.

### ARE CONDOMS EFFECTIVE?

Much debate surrounds condom promotion as a means to prevent HIV infection. Arguments against condom promotion are usually based on moral or ethical concerns. Medical and scientific research has shown that latex condoms, regularly and properly used, do prevent HIV transmission. Condoms also prevent transmission of most other STIs.

Condoms can be distributed by peer educators or through dispensing machines—whatever works—so that employees have ready and easy access to condoms. Because condoms are related to sexual behavior, some workers may be embarrassed to ask for them, so condoms should be available directly to workers without an intermediary.

#### 6.4 STI TREATMENT

Sexually transmitted infections are one of the most common health problems among workers. In many countries, STIs are among the top five reasons for health service consultations. The presence of an STI also greatly increases the possibility of transmitting HIV during sexual intercourse and increases one's susceptibility to HIV.

There is strong evidence from both community and workplace interventions that much lower STI rates among workers—and lower HIV rates—can be achieved. The best evidence comes from programs at and around mines in South Africa. Over a two-year period, STI rates among male miners and women in surrounding communities were reduced by 50 percent—and men were not acquiring a new STI at previously high rates. Another mine was so impressed with the results that it adopted the program for its own workers to reduce absenteeism and lower the risk for HIV/AIDS. Part of what made the program effective was reaching out to women in the surrounding communities and assuring that they had access to STI services and condoms (men had access to services through the mine clinics).

STI services, whether internally or externally provided, should be covered in the same way as other ministry or agency-sponsored services. The cost of STI diagnosis and treatment is often less than a worker's one-day wage, and the worker remains productive. Condoms, which can prevent the spread of STIs, are inexpensive and usually readily available. Should a

worker's STI be ignored, absenteeism and the resulting impact on productivity, medical fees and other expenses can be many times more costly than diagnosis and treatment.

STI services include information that encourages employees (and their partners) to learn about STIs, avoid transmission, and access medical services for diagnosis and treatment. To provide STI services, a workplace clinic needs medically trained personnel, some testing procedures and equipment, and adequate pharmaceutical supplies.

STI services should be provided not only to the employee, but to the employee's partner(s). If partners are not treated, the probability of re-infection is very high. The organization will want to work with medical providers and counselors to persuade patients with an STI to encourage their partners to seek treatment as well.

#### 6.5 HIV TESTING, COUNSELING, AND SUPPORT

Organizations are strongly discouraged from mandating HIV testing of employees or applicants. Voluntary, informed and confidential testing of employees and their partners is central to employee HIV prevention programs. There is growing evidence that voluntary HIV testing and counseling is an important tool in HIV prevention. Individuals who seek their HIV status are usually motivated to learn more about the disease and how they can protect themselves and their sexual partners. Many hospitals and NGOs provide these services.

Where HIV testing is conducted, it is essential that people tested receive pre-test and post-test counseling so they understand the nature of the test and its implications. Counseling for people who test negative emphasizes ways to remain uninfected. Counseling for people who test positive is more complex because of the deep fears, anger and uncertainty generated by

#### **VOLUNTARY, INFORMED, AND CONFIDENTIAL TESTING AND COUNSELING**

Voluntary means that the person is not coerced or manipulated into having the test; informed means that the individual understands what the test is, why it is being done, how it works, and what the consequences of the results are; and confidential means that the results will not be shared with anyone else without the person's full consent.

the result. Obviously, HIV counseling is a skill developed through training and experience. It also requires good interpersonal abilities.

#### **Support for Employees Infected and Affected by HIV**

The public service and unions can support people living with HIV/AIDS or care for affected people in numerous ways. Support groups for HIV-infected employees can be formed at the workplace, or employees can be encouraged to join off-site groups. In either case, employers should offer or negotiate flexible work schedules for participating employees (or for peer facilitators/counselors).

Support for infected employees can include helping to set up or paying for home-based care. This may have implications for the type of insurance or in-house financial support that each ministry or agency should arrange with its insurance providers. Another option for home-based care is ministry-, agency-, and union-sponsored fundraising to provide nursing care for terminally ill employees. This approach has been taken by a company in the South African coastal city of Durban. Also, in most countries, NGOs have extensive experience working with PLHA. These NGOs can provide training in home-based care, nutrition, legal counseling, and related support services.

As in many aspects of AIDS, care and support build on skills and resources from a collection of providers. Hospice and specialized facilities are relatively few and too expensive for most families. Thus, a combination of direct care by professional providers, family caregivers, community assistance, and coworker and employer contributions comprise the whole of care available to people. A significant employer contribution will be to track the range of service providers and make the information a part of the regular information component of the workplace program.

Emotional, psychological, and spiritual support can be provided through numerous social and faith-based community groups. In some instances, employees and their dependents will already know of or be part of these groups. In other instances, listing sources of social assistance and support available to employees can be part of a ministry's referral system.

#### **6.6 TREATMENT AND CARE FOR HIV/AIDS AND OPPORTUNISTIC INFECTIONS**

HIV infection is characterized by a progressive deterioration of the immune system. HIV-infected patients become susceptible to an expanding variety of opportunistic infections that take advantage of a weakened immune

#### **LEGAL SUPPORT**

Legal assistance for employees is offered directly or on referral by a handful of organizations. Unions and workers associations may be well placed to include this service for their members. Assistance can include preparing or up-dating wills, assuring that beneficiary clauses of life insurance policies are in order, providing for fostering arrangements of children, and using legal means to gain contracted benefits from employers and insurance companies.



system. Opportunistic infections often require hospitalization. They often are the immediate cause of death among HIV-infected people. But many opportunistic infections can be treated or prevented with existing drug regimens.

One of the leading HIV-associated opportunistic infections in developing countries is tuberculosis (TB). HIV infection contributes to reactivation of latent TB infection and makes individuals with recent TB infections more susceptible to rapid progression to active disease. Active TB, in turn, can accelerate the course of HIV infection. Active TB is unique among the opportunistic infections in that it does not remain confined to the individual, but it can spread to others, including coworkers.

A proven course of treatment is available for TB. In addition, preventive therapy is recommended as a health-preserving measure for HIV-infected persons at risk for TB, such as those with a positive TB skin test or who are living in areas where the disease is endemic. TB prophylaxis has been shown to increase the survival of HIV-infected persons at risk for TB. Given the low cost of TB therapy—\$5 for a year's supply of drugs—once a person is identified as HIV-infected, there is a strong case to provide TB prophylaxis. In addition, employers can create a supportive environment for HIV-infected patients on prophylaxis to adhere to treatment and scheduled evaluations.

Other opportunistic infections include forms of pneumonia, septicemia ("blood poisoning"), malignancies (cancers), and fungal and viral diseases.

Important advances have been made in preventing or delaying the onset of many opportunistic infections. Preventing opportunistic infections can significantly increase life expectancy and quality of life for PLHA—including the ability to continue to work.

The development of life-prolonging ARV drugs has raised great hopes. Lowered costs for such

drugs and government and NGO programs to provide them have increased access to them. A number of countries now provide ART to a small but growing number of PLHA. Numerous issues surrounding ART remain unresolved, including the ability of governments and citizens to pay for the drugs over several decades. Other countries and government ministries will face decisions about whether to provide drug treatments for HIV-infected employees (and perhaps their dependents). The decision will require careful review of existing ministry or agency policies on treating chronic illnesses (including HIV), the types of medical insurance coverage available to employees, the benefits derived from keeping skilled and trained employees on the job, and, of course, the costs involved. The decision involves a long-term perspective; ART and medical support are themselves long-term commitments.

Equity should be considered in decisions about ART provision. Some employers provide ART to certain classes of employees who are living with HIV/AIDS. For example, high-ranking military officers may be offered ART, but it may not be offered to all enlisted personnel. Another aspect of equity is whether to provide

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*"Lost in the fervor over securing the least expensive ART is the fact that there are several relatively inexpensive, generic antibiotics, with simple dosing requirements, to prevent or treat the opportunistic infections that cause death in AIDS."*

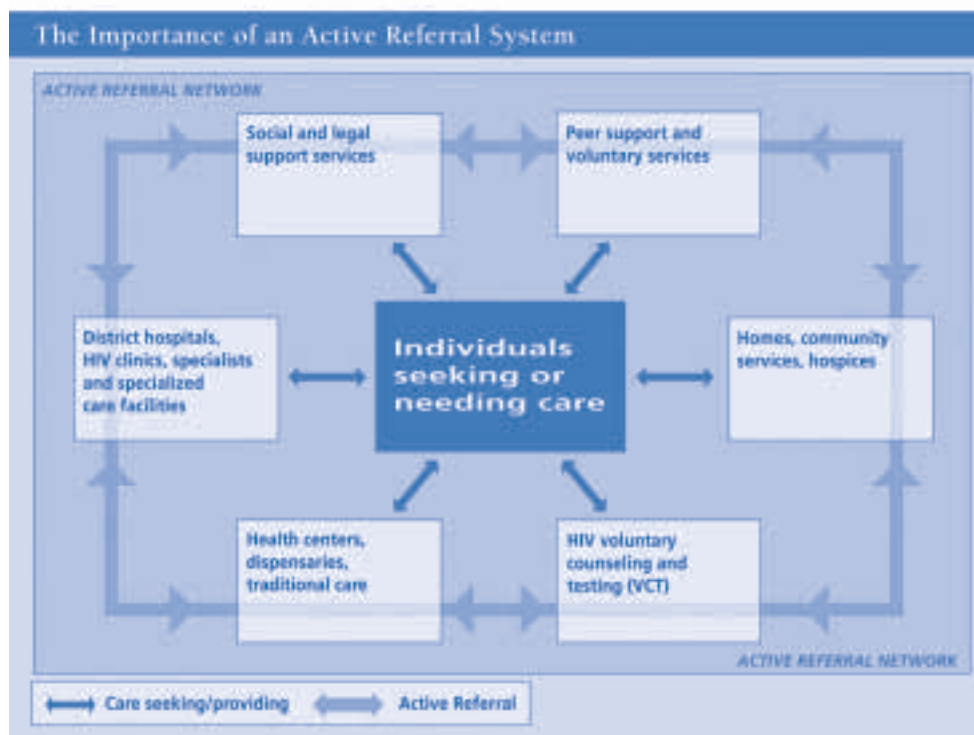
*— Jeffrey Laurence  
in The AIDS Reader (2001)*

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ART to spouses and other dependents of employees. A third aspect is cost-sharing. In some instances, employers or their insurance system may cover all drug costs and medical care for employees living with HIV/AIDS; in other cases, employees may be expected to pay a portion of the cost. Given the long-term



Figure 1.



nature of ART, at both policy and program levels, employers and unions need to carefully consider the best combination of ART coverage for government employees.

Numerous authorities have stressed the importance of a model for continuum of care—that is, an overlapping set of activities that assure access to appropriate care for PLHA. Figure 1 offers one such model.

## 6.7 UNIVERSAL PRECAUTIONS AND OCCUPATIONAL SAFETY

Some workers may be exposed to HIV through an accident or inadvertent move. This is most likely for health workers, but emergency service workers, traffic police and others may be exposed to blood or other body fluids.

“Universal precautions” provide guidelines to minimize the risk of accidental infection and protect workers from exposure to HIV in the workplace.

Universal precautions stress that all patients in medical settings should be assumed to be infectious for blood-borne diseases such as HIV/AIDS. Accidental needle-stick injuries are one of the most common forms of accidental exposure to HIV among health workers. Basic precautions to prevent accidental transmission of HIV also apply when working with people who are bleeding (due to a vehicle accident or interpersonal violence).

Most countries have adopted standard universal precaution procedures, although a lack of supplies and equipment often prevents staff from adhering to them. In other cases, regular

reminders about occupational risks and of the need to practice universal precautions are not provided during meetings or trainings.

Less extensive are training and guidelines to protect auxiliary health service personnel, such as cleaners or janitors who can be exposed to needles or blood when disposing trash, or cleaning equipment and rooms. Even less frequent are guidelines for police who respond to traffic accidents or victims of violent crimes.

All public sector offices should be prepared to deal with an accident in which blood is involved. All offices should have first-aid kits, and the kits should include gloves and disinfecting solutions such as bleach as an inexpensive and effective way to help prevent HIV infection.

Ministries and agencies can review national or WHO guidelines on universal precautions (see references) and update equipment and procedures.

## 6.8 PLANNING CHECKLISTS

The following checklists will assist in developing HIV/AIDS/STI prevention and care programs for a public service agency. The checklists will help planners consider options and will be useful when working with outside agencies that help develop or implement HIV/AIDS programs (see page 63).

The first checklist will guide users in determining which specific components of an HIV/AIDS workplace program to adopt. The second will assist in deciding what components the ministry or agency can design or operate itself and which will need outside assistance. A small team—with an employee representative and representatives from the human resources office and the medical/health/safety office—can build consensus around the prevention issues and generate other options.

The second checklist (page 67) centers around how the workplace prevention and care components will be managed. Organizations may decide to manage some components and not others, possibly identifying an outside organization to design and conduct overall management of the program. A variety of management arrangements can be adopted. These checklists can help when evaluating options for an HIV/AIDS workplace program.

## 6.9 HELP IN DESIGNING AND MANAGING AN HIV/AIDS PROGRAM

A comprehensive HIV/AIDS prevention and care/treatment program requires commitments of staff, time and resources. Those requisites may already exist within a ministry, or they can be supplemented with training on specific topics. In other instances, a skilled outside consultant or agency can address many of the issues for developing or expanding HIV/AIDS interventions. Organizations now exist with experience and skills in one or more components of a workplace program. Many of them can help design or implement a workplace program. They can offer training on relevant topics, provide ongoing support to in-house staff, work within a ministry for several months on specific assignments, and assess a program's effectiveness.

Part of the task for ministry authorities will be to contact such groups and negotiate an acceptable agreement for delivery of services. To find the best type of assistance or combination of skills, contacting two or more groups from the categories below is suggested.

- **National AIDS Commission or National AIDS Control Program.** Usually a part of the government, they often have access to international expertise and information and can usually assist in program design and monitoring.

- **Public and private sector medical staff**, such as specialists in HIV, STI, TB, or infectious diseases. These practitioners usually can provide information about or contacts at drug and other commodity suppliers.
- **Unions and worker associations.** National unions and worker federations have increasing experience with HIV/AIDS programs.
- **Nongovernmental organizations.** These groups often have the most direct experience in designing and implementing prevention and care programs. Some are large, others are small, and they have a range of skills and levels of expertise. Forming a coalition of NGOs can help draw upon various skills.
- **People living with HIV/AIDS.** Increasingly, people infected and affected by HIV/AIDS have created support groups, counseling and care facilities. Some of these groups also have experience in treatment protocols.
- **Other ministries** that have set up HIV/AIDS programs.
- **International organizations.** UNAIDS and other United Nations agencies have written practical guidelines and best practice experiences. Also, bilateral donor agencies are providing financial support and technical assistance to some governments and NGOs to initiate HIV/AIDS workplace programs.

## 6.10 MONITORING IMPLEMENTATION AND EFFECTIVENESS

There are several levels to monitoring the effectiveness of a workplace program.

- **Soliciting employee feedback.** Feedback can be informal, such as through a suggestion box or in casual conversations with co-workers. Feedback can be solicited via a formal process, by organizing meetings to ask about employee reaction to each component of the HIV/AIDS program. Human resource man-

agers, line supervisors and clinical officers can check with their staff to learn how they observe the functioning and acceptance of the program. HIV/AIDS focal point persons and supervisors will contribute views on acceptability of the program and perceived changes in attitudes.

- **Tracking changes in key indicators.** The indicators suggested in Chapter 2 for assessing the impact of HIV/AIDS remain helpful during program implementation. Month-to-month recording of absenteeism; medical retirements; production delays or disruptions; funerals and funeral attendance; and costs for clinical equipment, supplies, and drugs all will add to the understanding of change and effectiveness. Basic indicators for each program component can be developed and tracked on a regular schedule.
- **Periodic awareness or behavioral surveys.** An annual survey of employee awareness, knowledge or behavior will generate insights into the effectiveness of the organization's AIDS policies and programs. Surveys can focus on a specific aspect—such as how useful the peer education program is or attitudes toward PLHA—or a broad topic. Some NGOs are likely to have experience in designing and conducting such surveys.
- **Program evaluation.** An evaluation of the program's effectiveness may be feasible after three or four years, especially for ministry or agency programs supported by external resources. Evaluation design can be difficult and expensive—and raise ethical issues that need to be resolved—especially when assessing changes in behavior and HIV infection prevalence or incidence. Outside expertise probably is an appropriate option for most firms that decide to evaluate their HIV/AIDS workplace program.

**1. WHAT COMPONENTS OF AN HIV/AIDS PROGRAM ARE BEST SUITED FOR THIS MINISTRY OR AGENCY?** (Add a check mark and/or explanatory note in the appropriate box.)

	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
<b>1. An on-going behavior change Communication program with...</b>				
1.a. Up-to-date written materials for all employees				
1.b. Occasional information and updated present- ations on policies and programs				
1.c. Promotion of acceptable sexual behavior				
1.d. Awareness of risk related to drug misuse				
1.e. Support for conf- identiality and nondiscrimination				
1.f. Information about the ministry or agency HIV/AIDS policy and changes in the policy				
1.g. Promotion of treatment for STI, TB, and other infections for which services are available				
1.h. Information about and pro- motion of universal precautions to prevent on-the-job infection				
1.i. Support for and guidance on non- stigmatizing atti- tudes and behaviors toward PLHA				

	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
1.j. Information about (and encouragement of) using community HIV/AIDS services				
<b>2. Training for select staff</b>				
2.a. Peer educators				
2.b. Supervisors/worker safety representatives				
2.c. Worker support groups				
2.d. Manager peer groups				
2.e. Ministry or unit focal point person(s)				
<b>3. Condom distribution</b>				
3.a. Employees will have ready access to a regular supply of male condoms.				
3.b. Employees will have ready access to a regular supply of female condoms.				
3.c. Distribution points will be set up in the workplace.				
3.d. Information on correct use of condoms will be included.				
3.e. Ministry or agency will order condoms				
<b>4. STI diagnosis and treatment</b>				
4.a. Clinical facilities exist or can be upgraded on site				

	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
4.b. Clinical staff are or will be trained				
4.c. Ministry or agency clinic maintains regular supply of diagnostic and treatment equipment and drugs				
4.d. Privacy and confidentiality procedures are in place				
4.e. Information is available to all staff on outside sources regarding management of STIs				
<b>5. Counseling, testing for HIV, and support</b>				
5.a. Ministry or agency will train (or hire trainers for) counselors and support their work				
5.b. Ministry or agency can obtain HIV testing materials and information on test protocols, laboratory quality assurance and government recommendations				
5.c. Space is available for workplace counseling and testing				
5.d. Privacy and confidentiality procedures are assured				
5.e. Post-test counseling will be provided				
5.f. Ministry will encourage support groups for people living with or affected by HIV/AIDS				

	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
5.g. Information is available to all staff on home-based care providers				
5.h. Supervisors are trained to handle on-the-job situations of HIV-infected employees				
<b>6. HIV/AIDS/TB treatment and care</b>				
6.a. Ministry will offer (some/all) employees/dependents ART for HIV infection				
6.b. Ministry has clear procedures for determining who is eligible for ART				
6.c. Ministry has (or will create) a budget for cost of ART or increased insurance coverage that includes ART				
6.d. Ministry has (or will) arrange) to include ART in employees' insurance coverage				
6.e. Ministry will offer (some/all) employees/dependents access to treatment for AIDS-related opportunistic infections, such as TB				
6.f. Ministry will provide benefits for employees living with HIV/AIDS				
6.g. Ministry or agency will assure access to HIV drugs for pregnant employees and dependents to prevent mother-to-child transmission				

## 2. HOW WILL COMPONENTS OF AN HIV/AIDS PROGRAM BE MANAGED?

(Add a check mark and/or explanatory note in the appropriate box.)

	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
<b>1. Educational materials and presentations</b>				
1.a. Presentations on HIV/AIDS prevention				
1.a. Preparation and distribution of written materials				
1.c. Information about low-risk sexual behavior and workplace sexual harassment				
1.d. Distribution of ministry or agency AIDS policies and updates				
<b>2. Training of staff</b>				
2.a. Peer educators				
2.b. Supervisors and employee representatives				
2.c. Clinical staff, where appropriate				
2.d. Counselors				
2.e. Support-group facilitators				
2.f. Focal point persons on major HIV/AIDS issues				
2.g. Health facility and public safety staff in universal precautions				



	Ministry or agency now does this and will continue	Ministry or agency will consider or is planning to do this	Ministry or agency will consider or do this but is unlikely to manage it itself	Ministry or agency unlikely to do this
<b>3. Condom distribution</b>				
3.a. Ordering supplies				
<b>4. STI diagnosis and treatment</b>				
4.a. On-site facilities				
4.b. Supplies and drug availability				
4.c. Confidential record-keeping				
<b>5. HIV counseling, testing and support</b>				
5.a. Private facilities				
5.b. Confidential record-keeping				
5.c. Testing and diagnostic supplies				
5.d. Legal services				
<b>6. HIV/AIDS treatment</b>				
6.a. Drugs for opportunistic infections				
6.b. ARV drugs				
6.c. Drugs to prevent mother-to-child transmission				
6.d. Private and confidential medical records				
<b>7. Monitoring of quality and assessment of impact and effectiveness</b>				

## CHAPTER SEVEN

### MITIGATING THE IMPACT OF HIV/AIDS ON STAFF



This chapter covers:

- Factors to consider in reducing the impact of HIV/AIDS
- Factors to consider in managing ART provision
- A checklist to help develop mitigating actions



**HIV/AIDS has multiple implications for the smooth** functioning of public services. Besides causing prolonged absenteeism and the loss of key staff, the disease drains the public service of institutional memory, of tacit knowledge of the workings of institutions, and of new ideas and energy that younger staff members could bring to the work environment.

Government ministries and agencies can act in five key areas to mitigate the effects of HIV/AIDS on their workforces:

- Recruiting and training
- Changing job functions
- Revising personnel procedures
- Managing benefits and costs
- Assisting staff to manage care and treatment.

Each of these broad areas is discussed below, with examples of how various countries seek to reduce the impact of HIV/AIDS. The examples provide tested options; other options within each category are suggested.

### 7.1 RECRUITING AND TRAINING

The most obvious way to fill vacancies is to recruit new staff. But as most human resource officers know, there are obstacles to hiring new staff. In many instances, public service reforms have placed limits on staff recruitment; often, a position cannot be filled until it is officially vacant. Many staff living with HIV/AIDS have decided to stay in their positions despite lengthy absences. Ministries are unable to force retirement or hire temporary staff as long as a staff member remains on the roles. This has been the case with Uganda's Ministry of

Education and is true in several other African countries.

For procedural reasons, vacancies can take months or more to fill. In some cases, it is not possible to find suitable candidates with the desired qualifications and experience. In other cases, potential candidates are unwilling to join government service. Removing some procedural blocks to recruitment and promotion can accelerate hiring for key positions.

Recruitment of new staff also is inhibited by ministry decisions to delay or postpone recruitment to manage internal budgets. Having fewer staff is a way to keep ministry budgets in check.

Some ministries have adopted new training programs or procedures. In Zambia, primary schoolteachers are no longer required to complete two years of theoretical courses at teacher training colleges; rather, their training consists of a first-year theoretical course followed by a second-year placement in a classroom. Though the change did not occur because of teacher shortages, it has enabled the teaching service to fill gaps created by absenteeism and losses of teachers to AIDS.

Some countries are rehiring staff who retired or left the service for other reasons. People are brought in for special assignments, temporary

work, or to fill gaps. This involves maintaining contact with likely contract employees who can step into positions on relatively short notice. Agreements with employee unions to help identify and recruit temporary or contract workers may be feasible. Where salary and benefits packages can be upgraded, staff can be induced to return from the private sector.

Training can be offered to existing managers and supervisors so they can provide new forms of leadership and in-house skill building. This can occur through distance learning, nonformal training, and mentoring. Establishing an in-house leadership program to build management skills and career-path counseling for all employees may be feasible.<sup>21</sup> It is a way to upgrade the skills of existing staff and offer them further opportunities for advancement in the public service. The approach is common in North America and Europe and has been adapted for some managers in Namibia and South Africa.<sup>22</sup>

Succession planning is another important strategy. Where it is known or assumed that important personnel will be leaving the public service, an organization can prepare others to eventually step into those posts. The process can occur over months or years, and can involve further formal training; informal, on-the-job training; or both. Succession planning is distinct in that it is intentional. It includes an understanding, if not formal agreement, among senior officers, line supervisors, and human resource officers to equip likely candidates with the managerial, financial and personnel management skills to step into leadership positions. The Botswana Development Corporation has devised a form of succession planning that has “proved helpful in mitigating

the impact of temporary absence due to illness. Designated positions have a nominated assistant, who steps into the position when the job holder is absent for short periods. The assistant also continues with his or her own job, and receives compensation for the additional work and responsibility involved. This is seen as combining skills development with the management of lost time due to absence.”<sup>23</sup>

An important element of staff recruitment and retention is sustaining the flow of information required for the organization to do its work—and remembering what has been done in the past. Several studies of the effects of HIV/AIDS on organizations stress the critical loss of institutional memory.<sup>24</sup> Formal and informal information-sharing systems are part of knowledge management. Team meetings and exchanges, information storage and retrieval, regular staff updates, and other mechanisms all permit the flow of essential information. These information-sharing methods reinforce programs to upgrade staff proficiency and skills.

Other options for managing appropriate staffing levels and mixes include:

**1. Creating new cadres appropriate to actual working situations.** Examples are auxiliary nurses or local-level HIV/AIDS promoters. Nurses trained to provide voluntary counseling before and after a person has an HIV test can be recognized with a promotion or pay adjustment, for example. Each new employee would be oriented toward working with PLHA and affected families where they live and work. At one level, this is a job promotion scheme, which is badly needed for young people in many countries. At another level, it offers development opportunities for staff whose roles are to facilitate

21. Loewenson, R. and Whiteside, A. *Southern African Company Best Practices in AIDS and Employment*, 1999.

22. Aitken, J. M., with Kemp, J. *HIV/AIDS, Equity and Health Sector Personnel in Southern Africa*, EQUINET Discussion Paper Number 12, Regional Network for Equity in Health in Southern Africa (EQUINET), Harare, 2003. Published by UNAIDS.

23. Flint-Taylor, J. and Burch, G. *Scoping of the Options for Institutional Management of HIV-related Attrition*. Report prepared for the Department for International Development, 2001.

24. Ibid.

prevention, care and mitigation. Given the pressure to contain recurrent costs, the new cadres can be created for a fixed period (3–5 years, for example) as an emergency response.

**2. Adding incentives for certain staff to stay on the job.** Nonsalary incentives are likely to create the least amount of conflict among staff. Incentives can include new training opportunities or opportunities to attend conferences.

**3. Improving salaries and other conditions of service.** Tanzania, for example, plans to increase salaries of civil servants as a part of its public sector reform process. The government recognizes that to provide quality services, it must retain more staff. Pay is a part of that retention plan.

## 7.2 CHANGING JOB FUNCTIONS

Changing the types of work required or expected of staff occurs in many informal ways. Agriculture extension staff may be asked to assist in emergency food distribution. A teacher may be expected to cover for a head teacher who is attending a meeting. It is not uncommon to ask someone to assume some duties of a colleague who is on sick leave. Staff who share offices often pick up information about the work of their colleagues and can fill in on an ad hoc basis.

One way to build on this informal crossover in duties is to create teams of staff who share responsibility for a variety of functions. Teams can be created for specific activities—designing a workplace HIV/AIDS policy, for example—or they can be a regular part of an organization's work routine. Teams can allow junior members to learn from senior staff.

Another strategy is to formalize informal crossover by having staff become responsible for backstopping some tasks of one or more colleagues. This is a form of “multi-proficiency”

in which staff acquire and use a range of skills and knowledge to perform tasks outside the scope of traditional job descriptions. Short training sessions are a way for staff to learn about the skills and responsibilities of a colleague. While some opposition to taking on a wider set of tasks may surface, many staff will welcome the opportunity to learn new skills and to have greater diversity in their work. Human resource personnel, managers, and workers can identify positions most conducive to multi-proficiency. Clearly, highly technical jobs or jobs that require specialized knowledge may not be suitable for multi-proficiency arrangements. Multi-proficiency and task-sharing can prepare staff members to fill in for an absent colleague or to assume most of the tasks of another person.

Some jobs already require multiple skills. This is especially true of administrative and clerical jobs, which are usually held by women. Over several years in such positions, the staff become familiar with decision-making processes, internal procedures, issues of concern to the organization, and staff skills and relations. People holding these positions are often overlooked when it comes time to fill management and administrative positions with greater responsibilities. With some additional training they can readily and effectively assume more responsible positions.

As multisectoral structures to address HIV/AIDS were being established, an assumption in some ministries was that staff should become prevention advocates. Some ministries of agriculture trained extension workers to provide HIV prevention messages and distribute condoms to farmers as a part of their work. Usually, these responsibilities were entirely outside normal staff roles and many staff resisted assuming such duties. Some ministries of education have added sex education/life skills education to school curricula. Many teachers felt they were not adequately prepared to teach these subjects. Clearly, these experiences demon-

strate the need to consult with staff before making similar changes. If the changes are adopted, sufficient training is required to ensure that the new initiatives are effective.

### 7.3 REVISING PERSONNEL PROCEDURES

A change in personnel procedures is needed to change ways of recruiting, promoting and retaining staff. Existing procedures have been developed over years and decades; some may predate a country's independence. Civil service reform has already resulted in some important changes. HIV/AIDS requires further changes, especially to provide individual ministries and their managers greater flexibility in addressing staffing issues.

Revising personnel procedures to permit "fast track" responses to changes in staffing patterns and needs can help avoid or minimize disruptions caused by AIDS-related deaths or medical retirements. Eliminating procedures that have slowed recruitment or promotion in the past can quicken the hiring procedure. It may mean providing managers and human resource personnel with greater flexibility.

Staff infected or affected by HIV/AIDS can be transferred to locales where they have greater access to appropriate medical care, where they can care for a sick relative, or where their families can receive support. A case-by-case approach to the needs of staff living with HIV/AIDS affords supervisors and personnel departments flexibility in making placements. But a lack of clarity and consistency may leave some staff confused and frustrated. In line with the government or ministry HIV/AIDS policy, criteria for permitting exceptional transfers can be defined in personnel procedures.

Because sick leave of three to six months at full pay places a financial and staffing burden on ministries, some countries are discussing how sick leave policies can be changed to reduce the impact of HIV/AIDS on government

functions without over-burdening sick employees. Changes may involve reducing the length of fully paid sick leave granted to employees, establishing a special category of sick leave that allows positions to be filled, and encouraging medical or early retirement for chronically ill employees.

Many offices find it difficult to accommodate employees with HIV/AIDS who cannot fulfill their prescribed duties. Rather than redeploy an ill employ or provide that person with new skills for another position, offices often keep underperforming employees in their positions. This increases the stress of other employees who must fill the resulting gaps. Further, incapacity and ill health retirements are not managed consistently; some employees are provided with different work, others are ignored and allowed to stay in place. Redeployment is possible only if employees know their HIV serostatus and are willing to inform a supervisor. Given the stigma surrounding HIV/AIDS, few employees, up to now, have been willing to reveal this information. A more open and trusting work atmosphere can contribute to employees' confidence in being tested for HIV and sharing the result.

An HIV/AIDS workplace policy, backed with program support and supervisory training, can improve the ability to address staff incapacity, sick and compassionate leave, and ill-health retirement.

### 7.4 MANAGING BENEFITS AND COSTS

Benefits provided to public service employees have been a lasting attraction to the work. For many government ministries, HIV/AIDS has made providing these benefits more difficult and expensive. Suggesting even small changes in benefit packages can lead to strong employee opposition or support. Engaging employee representatives early in the process is important.

The following changes in benefits have occurred or are being considered within national civil services:

- Encouraging early retirement of chronically ill employees
- Restructuring sick leave to limit the time an employee can be away from the job
- Expanding compassionate leave for women and men who are caregivers for PLHA
- Designating guidelines for funeral attendance
- Consolidating medical aid schemes into a single scheme and defining the types of services to be provided and methods of cost sharing
- Providing bereavement counseling and legal assistance for affected employees
- Adding or increasing the copayment borne by employees for medical treatment and drugs.

One major decision to be made in the public service (either as a whole or by individual ministries) is whether to cover the costs of ART for employees and perhaps dependents. Managing ART costs will be a long-term consideration for managers. Two costing models are available. One is a model developed by The Futures Group that permits cost determination for a wide range of HIV/AIDS activities, including treatment and care. The other is a model offered by PHRplus that can determine potential costs of ART provision for employees and dependents. See lists of resources at the end of this guide for complete information on these tools.

Cost categories to be considered in decisions about ART provision include:

- Training
  - Medical, laboratory and support staff
  - Counselors to support for people receiving ART
  - Home-based care providers
- Capital costs
  - Laboratory equipment
  - Vehicles
  - New buildings or offices
- Drugs
  - ARVs
  - Opportunistic infections
  - Palliative care
  - Prevention of mother-to-child transmission
- Testing
  - Advertising and facilities for HIV counseling and testing
  - Counselors for HIV counseling and testing
  - Monitoring of highly active ART
  - Opportunistic infections

Human resource, medical and financial personnel should consider the range of costs thoroughly so they can define for decision-makers the options and related consequences. No single formula will fit all governments and perhaps not even all ministries within one country.

## 7.5 ASSISTING STAFF TO MANAGE CARE AND TREATMENT

A comprehensive workplace prevention program will merge with care and treatment as part of a continuum. Expanding access to HIV



counseling and testing enables staff and their dependents to learn their HIV serostatus. For those who are HIV-negative, counseling and testing reinforces safe sexual behavior. For those who are HIV-positive, it opens the door to seek care and treatment.

It is important to raise awareness of the workplace policy, of how the ministry promotes prevention, and of the range of prevention and care services available at or through the workplace. Ministries and agencies can raise awareness at several levels and with a variety of methods. For example:

- Distributing the workplace policy (for example, as part of an employee handbook and orientation guide)
- Providing peer education
- Encouraging and supporting employee HIV/AIDS groups
- Preparing guidelines on HIV/AIDS-related policies and procedures for supervisors and managers
- Designating an HIV/AIDS focal point person or expanding the number of focal points within a unit

Women in public service need additional support. This can be facilitated by:

- Establishing a clear policy, with references to HIV/AIDS prevention, against workplace sexual harassment (see Annex 1)
- Ensuring that pregnant staff (and women dependents of staff) have access to HIV counseling and testing prior to delivery and, if necessary, ART during birth
- Making specific statements within personnel procedures that recognize the role women play in caregiving and which afford women employees sufficient compassionate leave to provide necessary care for family members.

If feasible, staff may set up special funds to provide financial aid (as loans or grants) to employees affected by HIV/AIDS. One quasi-public organization in Côte d'Ivoire created such an employee-supported fund.

Ministries and employee unions can implement some initiatives at minimal cost. One of the most useful is a list of community resources available to employees for different HIV/AIDS-related needs. The list (or lists) need not be comprehensive; however, organizations or individuals included on such lists should be vetted for quality. Also, the lists should be updated at least annually. The lists can be distributed electronically, if internal e-mail exists, or in hard copy, perhaps along with pay packets. The lists can be distributed at once or sequentially as the information is gathered and compiled. In most countries and locales, existing organizations can provide relevant information to the government.

Among the topics that can be covered in resource lists are:

- Organizations and specific sites for employees to access voluntary HIV counseling and testing
- Public and private clinics and providers offering STI management
- Public and private clinics and providers offering treatment for opportunistic infections
- Organizations and providers offering reliable counseling and support on legal issues
- Organizations providing training and counseling for home-based care, including nutrition

## 7.6 PLANNING CHECKLIST

The following checklist will help human resources staff assess the staffing implications of HIV/AIDS. The checklist will help identify reasons for staff shortages, areas where per-

sonnel procedures may need to be reviewed, and areas where benefits may change. Questions in the checklist are designed to stimulate discussion about changes in staffing processes to reduce the impact of HIV/AIDS. Some answers can be used to better inform ministry decision-makers about needed changes to mitigate the effects of HIV/AIDS on operations.

The checklist is not comprehensive. Each public service unit can add other questions and points that reflect their unique concerns and internal structures. Note that the term “unit” refers to any size component of the public sector—from the entire civil service to a quasi-public agency.

## PLANNING CHECKLIST FOR MITIGATION ACTIONS

INFORMATION MANAGEMENT		
	Response	Comments
Is there a functioning <b>data collection system</b> that provides information on vacancies, retirements, deaths, absenteeism and length of service?		
Does the data collection system <b>differentiate</b> by gender, age and locale of the post of staff?		
Has a <b>personnel HIV/AIDS impact study</b> been performed within the past year?		
If so, how have the findings been used for: planning, policy development, personnel procedure changes, program design/implementation?		
Has a <b>personnel planning study</b> been prepared within the past one or two years? If so, did it include HIV/AIDS-related issues? Is there an obligation or expectation that the personnel planning study will be revised and updated on a regular basis?		
Is there evidence of <b>long-term vacancies</b> in key positions or certain personnel categories?		
What is the average <b>length of time</b> to fill vacancies?		
What are the <b>reasons for those long-term vacancies</b> ? Hiring freeze? Unable to find suitable candidates? Internal recruitment procedures take time? Other?		
What has been the <b>trend</b> over the past five years in filling vacancies: has it taken more time, less time, or about the same amount of time than in the past?		
Does the ministry maintain adequate <b>records to monitor changes</b> in staffing conditions?		
STAFF RETENTION, RECRUITMENT, AND TRAINING		
	Response	Comments
Is there a policy or plan to <b>retain staff</b> ?		
Are staff offered <b>incentives to remain</b> in public service? If so, list or describe the incentives?		

## STAFF RETENTION, RECRUITMENT, AND TRAINING *(continued)*

	Response	Comments
Are there discussions or plans to <b>add or alter the incentives</b> given to staff?		
Are <b>staff regularly informed</b> about existing or new incentives?		
What are the <b>most time-consuming</b> factors in recruiting new staff?		
Is there evidence of staff <b>shortages even where posts have been authorized</b> ?		
What does it <b>cost to recruit</b> staff for various personnel categories?		
Is there <b>information to determine</b> the cost of recruitment?		
Does the ministry offer (or is it considering offering) <b>incentives to retain</b> personnel?		
Has the ministry sought to <b>rehire retired</b> staff?		
Does the ministry provide HIV/AIDS <b>policy and program information</b> to new recruits?		
Do the ministry's <b>training programs for new and established staff</b> include modules on HIV/AIDS prevention, care and treatment, and personnel procedures related to AIDS?		
Does the ministry offer forms of <b>leadership and management development</b> ? If so, do those methods adequately meet the existing vacancies?		
Do the ministry's training programs include presentations and discussions on established <b>codes of conduct</b> related to HIV/AIDS?		
Has a manual or have basic <b>guide lines</b> been prepared <b>for supervisors/managers</b> on addressing key elements around HIV/AIDS in staff procedures—such as sick and compassionate leave, stigma and discrimination?		

## JOB FUNCTIONS

	Response	Comments
What <b>changes</b> , if any, have occurred in <b>job functions</b> within the major personnel categories over the past three years?		
Have <b>staff voiced concerns</b> , complaints, or support for the changes, or about assuming new or excessive duties?		
Have staff expressed concerns or complaints about <b>excess duties</b> or work? Note some of the major concerns or complaints.		
Have staff been asked/required to <b>assume duties entirely outside their normal areas</b> or responsibility (e.g., extension agents distributing condoms)?		
Are people kept in <b>acting positions</b> for more than 3–4 months?		
Does the unit use <b>work teams</b> to complete some tasks?		
Have <b>work teams been used to compensate for gaps</b> in staffing or because some key people were not available?		
Does the unit encourage <b>multiproficiency</b> —learning of tasks normally performed by one person?		
Does the unit place people in <b>more responsible positions without adequate training</b> or supervision?		
Are <b>clerical and administrative staff</b> encouraged to assume more responsible roles?		
Is there a formal or informal policy of <b>promoting clerical and administrative staff</b> into more responsible positions?		
Is the unit HIV/AIDS <b>focal point person</b> able to access training to gain new information and skills?		
Is the unit HIV/AIDS focal point person responsible for <b>other duties</b> than addressing HIV/AIDS issues? Do the focal point persons feel they are able to devote sufficient time to HIV/AIDS issues?		
Does the HIV/AIDS focal point person have <b>regular contact with and access to senior managers</b> ?		

PERSONNEL PROCEDURES		
	Response	Comments
When was the last time significant <b>changes were made in personnel procedures</b> that affected most or all staff?		
What <b>lessons were learned</b> during adoption and implementation of those changes?		
Are personnel procedures generally <b>enforced</b> or do managers have great flexibility in interpreting and enforcing them?		
Does the current <b>sick leave policy</b> make it difficult to hire temporary or replacement employees?		
Is the current <b>compassionate leave policy</b> sensitive to the caregiving role and needs of women employees?		
Do employee <b>transfer policies</b> contribute to HIV/AIDS risk?		
Does the unit have guidelines for <b>job accommodation</b> (redeployment, retraining) for PLHA?		
Do procedures permit supervisors/ human resources officers to <b>“fast track” new hires</b> ?		
Are <b>death benefits</b> readily distributed to dependents?		
Are standard <b>medical retirement procedures</b> usually followed? If not, why?		
Has a <b>list (or inventory) of employee benefits</b> affected by or related to HIV/AIDS been developed?		
Has a <b>cost assessment</b> been conducted for employee benefits?		

## BENEFITS

	Response	Comments
Has the government or specific ministry discussed or adopted <b>changes in benefits provided to people living with or affected by HIV/AIDS</b> ?		
Is provision of any available benefits determined on a <b>case-by-case basis</b> ? If so, are supervisors, unions and other employees satisfied with this procedure?		
Does the unit offer PLHA <b>workplace accommodations</b> or redeployment suitable to their needs?		
Where employee are required to belong to <b>medical aid schemes</b> , are benefits sufficient to cover potential HIV/AIDS treatment?		
Where employees are excluded from a medical aid scheme (because of rank), what <b>options exist to assist</b> them if they or a dependent requires HIV/AIDS treatment?		
If belonging to a medical aid scheme is optional, are the alternatives for employees <b>adequate to meet potential needs</b> for treatment and other medical care?		
Does the unit include <b>compassionate care leave</b> for employees caring for a family member with HIV/AIDS?		
Does the unit provide employees with <b>updated information</b> on community HIV/AIDS resources?		
Has the unit or employee representative negotiated with the <b>pension authority</b> in light of needs of PLHA and affected families?		
Do staff living with HIV/AIDS who leave public service have a right to <b>continued access to medical benefits</b> ?		

## CHAPTER EIGHT

### COSTING HIV/AIDS WORKPLACE PROGRAMS



This chapter covers:

- Factors and details to help assess the cost of HIV/AIDS workplace interventions





While ministers increasingly recognize the need to safeguard their workers from HIV/AIDS, few ministries have allocated money for such work. Most government units work with tight budgets, and adding new line items, such as for an HIV/AIDS program, may result in displacing funds for other activities.

It is important for government offices to make informed and reasonable assessments of the costs of effective workplace prevention and care programs. Some governments may assign the task of determining costs to the ministry of finance or to the public service commission. In other cases, individual ministries or agencies take the initiative to develop and fund HIV/AIDS activities.

While investing in HIV/AIDS programs is important, many aspects need not be very expensive. It is not necessary, in most cases, to replicate materials or services that already exist. Many ministries of health and NGOs run HIV counseling and testing centers, provide training for home-based care, and operate psychosocial support services, STI clinics and other services. Faith-based groups and NGOs provide support for PLHA and their dependents. Providing employees and their dependents with lists of services and resources is not only inexpensive, but it is a major form of assistance. Written materials about HIV/AIDS already exist in most countries; these can be used or adapted for new audiences.

There is no standard costing model that covers all countries or all aspects of a full HIV/AIDS prevention, care and treatment, and mitigation program. Program costs are influenced by a number of factors:

- The level of HIV infection among government employees (and among dependents, if government benefits extend to them)
- The scope of the overall HIV/AIDS program
- The level of cost-sharing for benefits (especially health and death/funeral benefits) between the public service and employees
- How early and quickly a workplace program is set up (an early, effective prevention program will be less expensive than one started after employees are infected)
- Costs of living (and related salaries and benefits) in each country

The following points will help public sector planners and decision-makers determine the costs in creating or expanding an HIV/AIDS workplace program. Some of the costs are likely to be residual. For example, as more public servants seek medical care for HIV/AIDS, medical aid schemes may increase the premiums paid by government to manage the increased costs.

The costs noted here may be covered in a ministry or agency budget. They do not include the costs of improving or expanding health care systems to provide more or new services. Nor do they include the costs that individual employees and their families incur for care and

treatment. New pressures on ministries or the civil service as a whole may arise as employees (and their dependents) living with HIV/AIDS seek government or union assistance in meeting the financial burdens of the disease. The costs of home-based care and costs normally covered by medical aid schemes are described here nonetheless.

### 8.1 COSTING PREVENTION

The costs to a government agency for prevention are likely to be modest. They include:

- Identifying existing relevant awareness and other educational materials
- Providing referral information for HIV counseling and testing and STI management to employees
- Training and covering the costs of in-house peer educators
- Acquiring and distributing male and female condoms
- Covering the salary of an HIV/AIDS focal point person or a focal point team.

Although it may not be necessary to develop new educational materials, offices may wish to update or adapt some existing materials; printing additional copies of existing or updated materials will incur some modest costs.

Important prevention activities, such as those for HIV counseling and testing and for treating STIs, will usually occur outside the workplace. The costs of obtaining these services are likely to be met by the employee, with some or all coverage provided by medical aid schemes. Some employees will seek to pay for such services themselves, in an effort to seek greater privacy.

A study conducted in the South African private sector found that companies spent \$10–\$15 annually per employee on HIV/AIDS prevention programs and “achieved substantial reductions in the infection rate.” While these returns on the investments made by the companies in HIV/AIDS prevention programs were not always large, “the fact that they were positive suggested that companies should invest more in HIV prevention programs.”<sup>25</sup> A public sector-owned bank in Indonesia spends \$3.25 per employee annually on its HIV/AIDS prevention program. Although the program is more modest in scope than the South African example, the bank management believes the investment will bring significant savings in preventing HIV infections that would be far more costly over the long run (see Case Study 4).

### 8.2 REPLACING LOST WORKERS

There are both direct and indirect costs to replacing lost workers. The direct costs are easier to quantify, but they do not provide a complete picture of total costs. Direct costs include:

- Advertising to solicit applicants for positions
- Reimbursement for travel or per diem payments during interviews
- A portion of the salary of recruiters and interviewers
- Any bonus or related payments to hire select staff (this may apply primarily to the hiring of expatriate staff)
- Travel and relocation expenses for new staff

Indirect costs include:

- Lost productivity while a position is vacant (but this may be partially offset through savings by not paying salary and benefits for a staff person)

25. Rosen, Sydney, J. Simon, J. Vincent, W. MacLeod, M. Fox, D. Thea. *AIDS Is Your Business*. Harvard Business Review, February 2003. Reprint R0302F.

- Lost productivity while new staff become acquainted with the position and organization
- Time for supervisors to train and acquaint new staff with position functions
- Additional training required of new staff
- Effects on morale and efficiency (including absenteeism) of other staff who must fill in to cover vacant positions

Vacancies among staff who are serving clients, such as teachers or health clinic staff, may cause clients to incur costs in the form of longer waiting periods to obtain services, less attention from staff, and a lower quality of services.

### 8.3 HOME-BASED CARE

There are numerous models of home-based care, each with different costs. Hospice Uganda estimates the cost of providing care to one patient who lives at home at \$11 per week. A contribution of \$2.50 by the patient or by the patient's family is expected unless the family cannot afford the fee. End-of-life hospice care may extend over as little as one week or as long as six months. A study in South Africa found wide variations in the cost of home-based care, largely related to the quality of care being offered. The monthly cost per patient ranged from \$8.50 to \$77.

A home-based care model in South Africa consists of educating family members about nutrition, wound care, providing medicine to the patient, and being the patient's communication link to medical providers. The project monitors PLHAs' drug-intake for opportunistic infections, and its volunteers provide care to the terminally ill. Like other successful care projects, the model makes extensive use of

volunteers and available community resources. Costs are kept low, usually limited to training and program management by an outside organization. Other home-based care initiatives encourage the formation of support groups and income-generating activities. These support groups are mechanisms to help "build self-confidence, cope with being HIV positive and overcome depression, by creating support networks for people who are isolated. After participating in a support group, some clients were able to disclose their status to a family member."<sup>26</sup>

Unions and employers may want to negotiate with medical schemes or insurance companies to include all or a part of the costs of home-based care for workers and dependents. As an alternative to employee absences (or leave-taking) to care for a sick dependent, the cost of providing assistance in the home is marginal and may be cost-effective to the organization.

### 8.4 MEDICAL CARE

Medical costs include outpatient visits to doctors' offices, clinics or hospitals, and inpatient care in a hospital or a clinic. A study in Honduras found that in 2001, the cost of an outpatient visit to obtain treatment for an HIV/AIDS opportunistic infection was nearly \$24, which included drug costs. The study found that seven annual visits were the norm, making the annual cost close to \$166. The daily cost for an average hospital stay for a PLHA was \$148, without the cost of ART.

In one province of Thailand, the cost of an outpatient visit to receive ARV drugs was \$26, not including the cost of the drugs. An inpatient stay per day, without ARV drugs, was nearly \$44.

A detailed study of medical care costs for civil servants living with HIV/AIDS in Côte d'Ivoire

26. Russel, Michele and Schneider, Helen. *A Rapid Appraisal of Community-based HIV/AIDS Care and Support Programs In South Africa*. Centre for Health Policy, University of Witwatersrand, Johannesburg. 2000 (<http://www.kznhealth.gov.za/AIDScare-supportprograms.pdf>).

found that the lifetime treatment costs in mid-1995 were just over \$1,000. About 40 percent of that total was for hospitalizations. ARV drugs were not available at the time of the study; drugs to treat opportunistic infections accounted for about 8 percent of the total.

The benefits of treatment programs in the private sector have been studied widely. One of the most extensive studies, from companies in South Africa, found that providing free ART at every level of the workforce, rather than absorbing the direct and indirect costs of HIV/AIDS, made financial sense.<sup>27</sup>

## 8.5 QUANTIFYING THE BENEFITS

While it costs money to mount and sustain HIV/AIDS programs, those programs save money. In the public sector, costs of starting programs are usually considered more important than the cost of running them, because creating a program requires an outlay of money, which is scarce. Many managers look to these costs without considering the money being saved with effective prevention, care and treatment programs for employees.

Among the monetary savings that will be achieved are:<sup>28</sup>

- **Reduced paid sick leave.** Employees who quit their jobs due to AIDS take an average of 27.7 additional paid sick days in each of the two years before termination, for a total of 55.5 days. This estimate may be modest because other estimates show that a typical employee of a South African company loses about 250 productive days over the course of the illness.

- **Pension and death benefits are spread into the future.** Pension payments to employees who stop working because of HIV infection—and payments to their beneficiaries when they die—can be as much as three times the employee's annual salary.<sup>29</sup>

- **Reduced costs associated with recruitment and training.** The private sector recruitment and training costs in South Africa are, on average, \$1,200, but they may reach as much as \$4,000 for executives and managerial staff.

- **Reduced medical and drug costs.** Savings will be generated by prevention initiatives and treatment of opportunistic infections for PLHA.

Non-monetary savings come in improved efficiency, fewer disruptions in delivery of services and in daily work, and less stress on remaining employees. In addition, treatment of HIV infection and opportunistic infections prolongs the work life of employees, and reduces sick leave, as well as pension and recruitment costs.

27. Rosen, Sydney, J. Simon, J. Vincent, W. MacLeod, M. Fox, D. Thea. *AIDS Is Your Business*. Harvard Business Review, February 2003. Reprint R0302F.

28. Adapted from Sydney Rosen, et al. "Care and Treatment to Extend the Working Lives of HIV-Positive Employees: Calculating the Benefits to Business," *South African Journal of Science* (July 2000).

29. Some companies offer far less than three times the employees' annual salary, others will provide even more. According to several sources provided by Rosen (see footnote 28), the averages range from three to four times the annual salary.

## COSTS OF HIV/AIDS PREVENTION AND PROGRAMS: EXAMPLES

Volkswagen do Brasil has provided treatment and support services for HIV-infected employees since 1996. Treatment includes access to medical specialists, access to antiretroviral drug treatment, clinical monitoring of the drug treatment, home care and help returning to the workplace. By the end of 1999, the company reported that its monitoring systems showed a 90 percent reduction in hospitalizations, a 40 percent reduction in costs for treatment and care--and that 90 percent of the patients were active and without symptoms. "The experience of Volkswagen do Brasil has provided evidence of the effectiveness and costs savings to companies initiating ... coordinated and specialised treatment and care to its workforce. The saving from reduced absenteeism and loss of employees is central to this approach," according to one report.

Source: *The Business Response to HIV/AIDS: Impact and Lessons Learned*. Joint United Nations Programme on HIV/AIDS, Prince of Wales Business Leaders Forum, and Global Business Council on HIV&AIDS, Geneva and London, 2000.

The electricity-generating company in South Africa, Eskom, has run a comprehensive HIV/AIDS prevention program for its employees since the mid-1990s. Education, condom distribution, STI diagnosis, treatment and care are part of the program. An annual review of the costs of the prevention program found that Eskom spends about \$20 per year per employee, far less than the cost of recruiting and training new employees for most positions.

Debswana, a public-private diamond mining partnership in Botswana, concluded after extensive analysis and internal discussion that providing ART to employees living with HIV/AIDS was expensive but cost-effective. During the first year of implementation, the cost of the ART program was 10 percent of the annual personnel payroll. Within three years, that cost (due to the declining cost of drugs and internal efficiencies) dropped to 3.5 percent of the annual personnel payroll.

Source: *The private sector responds to the epidemic: Debswana—a global Benchmark*, UNAIDS case study, Geneva, 2002.



## APPENDICES

### HIV/AIDS AND THE PUBLIC SECTOR WORKFORCE



#### A. Resources

#### B. Glossary

#### C. Case Studies

1. Ghana's Customs, Excise and Prevention Services HIV/AIDS Program
2. HIV/AIDS Prevention with Cambodia's Military and Police
3. Zambia's Education Sector
4. Prevention in an Indonesian Bank

#### D. Annex

1. Botswana's Sexual Harassment Policy
2. What is Behavior Change Communication?





## APPENDIX A: RESOURCES

### GENERAL BACKGROUND

Family Health International (a co-publisher of this guide) has more than 20 years of experience in HIV/AIDS prevention, care and workplace programs. Check the organization's website ([www.fhi.org](http://www.fhi.org)) for an extensive collection of HIV publications, including those addressing workplace issues.

The Futures Group (also a co-publisher of this guide) has developed an extensive set of computer modeling software to help estimate costs and manage HIV/AIDS workplace issues ("Workplace Policy Builder" software). It also maintains a database of national HIV/AIDS policies. The organization is developing a software package for drafting HIV/AIDS policies. These resources can be accessed at: [www.futuresgroup.com](http://www.futuresgroup.com)

Desmond Cohen. *Human Capital and the HIV Epidemic in Sub-Saharan Africa*. International Labour Organization, Geneva, 2002. [www.ilo.org/public/english/protection/trav/aids/publ/index.htm](http://www.ilo.org/public/english/protection/trav/aids/publ/index.htm)

The International Labour Organization has a module on HIV/AIDS in the "Your health and safety at work" series that is designed for worker representatives. It can be found at: [www.itcilo.it/english/actrav/telearn/osh/aids/amain.htm](http://www.itcilo.it/english/actrav/telearn/osh/aids/amain.htm)

Health Economics & HIV/AIDS Research Division (HEARD) at the University of Natal in South Africa developed a set of papers known as the AIDS Toolkits. The short papers cover many of the major public service sectors. Although now somewhat dated, they provide an overview of factors to consider in expanding prevention and care programs for govern-

ment ministries. The papers are available at: [www.und.ac.za/und/heard/](http://www.und.ac.za/und/heard/)

### ASSESSING THE HUMAN RESOURCE IMPLICATIONS OF HIV/AIDS

Tony Barnett and Alan Whiteside. *Guidelines for Preparation and Execution of Studies of the Social and Economic Impact of HIV/AIDS*. UNAIDS, Geneva, 2000.

### POLICIES AND ADVOCACY

POLICY Project. *Moments in Time: HIV/AIDS Advocacy Stories*. Washington, DC, 2003. (<http://www.policyproject.com/stories>)

POLICY Project. *National and Sector HIV/AIDS Policies in the Member States of the Southern Africa Development Community*. Washington, DC, 2002.

### MANAGING RESPONSES TO HIV/AIDS IN THE WORKPLACE

Family Health International. *Uniformed Services HIV/AIDS Peer Leadership Guide*. Arlington, Virginia, 2001.

This is a useful guide on how to develop behavior change communication programs.

Family Health International. *Workplace HIV/AIDS Programs: An Action Guide for Managers*. Arlington, Virginia, 2002.

The book provides guidelines for addressing HIV/AIDS in private sector companies. It is also available in French.

Global Network of People Living with HIV/AIDS. *Positive Development: Setting up self-help groups and advocating for change. A manual for people living with HIV*. Amsterdam, 1998. ([www.gnp-plus.net/programs.html](http://www.gnp-plus.net/programs.html))

This is a useful, detailed guide for forming support groups and conducting advocacy for PLHA.

Management Sciences for Health. *Human Resource Management Assessment Tool for HIV/AIDS Environments*. Arlington, Virginia, 2002.

The tool is divided into 20 categories relating to human resources management for HIV/AIDS. Users are encouraged to respond to specific issues that lead to a workplace action plan. It is a useful starting point, but probably too general for most in-depth planning situations.

South Africa Department of Public Service and Administration. *Managing HIV/AIDS in the Workplace: A Guide for Government Departments*. Pretoria, 2002. (<http://www.policyproject.com/byTopic.cfm/hiv>)

This is one of the most thorough efforts to outline the multiple issues facing the public sector in addressing HIV/AIDS.

South Africa. *Full Report of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector*. Pretoria, 2003. (<http://www.gov.za/reports/2003/ttr010803final.pdf>)

This is a useful national study that includes information on cost of providing care and treatment.

Kathy Attawell and Jackie Mundy. "Provision of antiretroviral therapy in resource-limited settings: a review of experience up to August 2003," draft paper, WHO and DfID, London, 2003. (<http://www.eldis.org/cf/search/disp/docdisplay.cfm?doc=DOC13960&resource=f1hiv>)

UNAIDS. Peer Education Kit for Uniformed Services: Implementing HIV/AIDS/STI peer education for uniformed services. Geneva 2003.

World Health Organization on universal precautions: (<http://www.who.int/hiv/topics/precautions/universal>)

## COSTING PROGRAMS

The Resource Needs Model developed by Futures Group can be used to estimate the cost of HIV/AIDS interventions, including treatment costs. The software and a users guide can be accessed at <http://www.futuresgroup.com/WhatWeDo.cfm?page=Software>

Futures Group also has developed a model for assessing levels of budget support for HIV/AIDS initiatives. The model is called Goals Model. The software and a manual can be downloaded at: [www.futuresgroup.com/WhatWeDo.cfm?page=Software](http://www.futuresgroup.com/WhatWeDo.cfm?page=Software)

PHRplus has developed an ART costing model. The software and a users manual can be downloaded at: [www.phrplus.org/hiv-atc.html](http://www.phrplus.org/hiv-atc.html)

Gilbert Kombe and Owen Smith. *The Costs of Anti-Retroviral Treatment in Zambia*. Partners for Health Reformplus. Bethesda, Maryland, 2003.

## APPENDIX B: GLOSSARY

**Abstinence:** Refraining from sexual intercourse

**Acquired immune deficiency syndrome (AIDS):** The late stage of HIV disease. AIDS is characterized by the loss of function of the immune system as CD4 cells are infected and destroyed, causing the body to succumb to opportunistic infections that are generally not pathogenic in people with intact immune systems. Common symptoms of AIDS include malignancies and wasting syndrome.

**AIDS service organization (ASO):** An organization that provides care, education or other services to people with HIV/AIDS.

**Antiretroviral therapy (ART):** Drugs, nutritional care, medical attention and psychosocial support provided to people living with HIV/AIDS. In most cases, the therapy will prolong the lives of HIV-infected individuals.

**Antiretroviral (ARV) drugs:** The drugs that suppress a retrovirus, such as HIV. All of the anti-HIV drugs—AZT, protease inhibitors, etc.—are considered antiretroviral drugs.

**Cofactor:** Factors that increase the probability of the development of disease. For example, sexually transmitted infections such as gonorrhea and chlamydia are cofactors in HIV transmission.

**Compassionate leave:** Absence from work to manage acute personal issues, such as to care for a sick relative or to attend a funeral.

**Discrimination:** The denial of opportunities or benefits, otherwise available to everyone, to a person or group because of real or assumed features or conditions of the person or group.

**ELISA:** A blood test that detects the presence of antibodies to HIV, used to determine whether the patient is infected with HIV. The term stands for enzyme-linked immunosorbent assay.

**Highly active antiretroviral therapy (HAART):** A combination of three or more antiretroviral medications—each of which affects the virus in a different way—to treat people infected with HIV.

**Human immunodeficiency virus (HIV):** The virus that leads to AIDS. The virus is acquired through sexual intercourse, sharing of infected needles and cutting instruments, contaminated blood supplies, and mother-to-fetus or infant transmission. The virus remains in the body for 5–10 years or more before full symptoms of opportunistic infections or AIDS appear. The virus is detected in the blood stream through the ELISA test.

**Incidence:** The number of cases recorded in a specific time frame.

**Nongovernmental organization (NGO):** A group that functions outside of formal government structures. NGOs provide a variety of program services and advocacy around HIV/AIDS.

**Opportunistic infection:** A normally benign microbe or virus that causes a disease in persons with a suppressed immune system.

**Peer education:** The sharing of information by people of similar backgrounds and experiences as the audience (such as similar ages, occupations, or life experiences).

**Policy:** A framework or set of guiding principles that describe an organization's values, expectations, principles, and responsibilities to its employees and the public.

**Prevalence (prevalence rate):** The number of individuals with a condition in a specific population. The prevalence rate is determined by dividing the number of people with the condition by the total population.

**Primary care:** Basic medical care; the first line of medical management of a condition.

**Protease inhibitor:** A class of anti-HIV drug that prevents creation of an HIV-specific protease.

**Sexually transmitted infection (STI):** A virus or bacteria transmitted between sexual partners. STIs that remain untreated usually result in a sexually transmitted disease (STD)

**Stigma:** Negatively perceived characteristics affecting a person or group. Stigmatization is the labeling of persons with the negative features, such as people who are (or are considered) to be HIV-infected.

**Susceptibility:** The features of an organization that make it more or less likely that its workers will contract HIV infection.

**Syndrome:** A set of symptoms that occur together.

**Universal precautions:** Procedures to prevent accidental HIV/AIDS infection in the workplace. Usually applied to medical settings, but universal precautions are relevant for any public sector worker—military, police, and other emergency workers—likely to come into contact with blood.

**Virus:** Any large group of submicroscopic agents capable of infecting plants, animals, and bacteria. They are characterized by a complete dependence on living cells for reproduction and by a lack of independent metabolism.

**Vulnerability:** The aspects of an organization that make it more or less likely that unusual levels of illness (or deaths) will have negative effects on the functioning and performance of the organization.

## APPENDIX C: CASE STUDIES

### CASE STUDY 1: GHANA'S CUSTOMS, EXCISE AND PREVENTION SERVICES HIV/AIDS PROGRAM

Ghana's Customs, Excise and Prevention Services (CEPS) officers are often posted to border posts and remote locales. It is not unusual for some of them to travel without their families or be away from home for extended periods of time. The regular salaries of the officers are considered another risk factor, because the officers attract attention from women and men in the community, and they can use their incomes and influence to gain sexual favors.

In 2000, Family Health International began working with the CEPS of Ghana. This relationship marked the beginning of an aggressive prevention program designed to sensitize the 3,800 members of the service about HIV/AIDS and STI, and to protect the service from loss of personnel.

At the time, national HIV/AIDS prevalence was about 2 percent, which is considered low. AIDS was a concern, but not a major priority, of a new government that took office in 2001. But a baseline sexual behavior survey among CEPS officers demonstrated the potential for HIV to rapidly spread and eventually reduce the capacity of the service to fulfill its duties. The survey found that "quite a number of officers have other partners apart from their spouses or regular partners." At least one-third of the respondents had sex with non-regular partners two or more times per month. Awareness of HIV/AIDS existed, but behaviors had not substantively changed. More than one-third of women and men who responded to the survey recognized that they faced some risk of HIV infection because of their sexual behavior.

Adding urgency to the findings was that three-quarters of those surveyed at land border posts believed they were at risk.

A 47-member team, with officers from different regions of the country and headed by an assistant commissioner, was set up to design, coordinate and monitor the program's activities. A training manual for peer educators initially designed for the Ghana Police was adapted to the needs of CEPS. The plan was to train four peer educators from each of the 66 CEPS stations. That target was not reached, but nearly 140 men and women were trained as peer educators. Eventually, every station had one or two peer educators. An additional five officers were trained using a curriculum designed to bring HIV prevention education into the CEPS Academy where new recruits received their training and officers attended fresher courses.

Being a peer educator was voluntary, and officers were expected to fulfill their regular duties in addition to promoting HIV/AIDS prevention. Initially, it was difficult for most peer educators to do both jobs, but over time, most found ways to balance the demands. Supervisors, too, showed increased willingness to allow flexibility in work routines.

Within a year the project management team was getting sufficient feedback to confidently believe that awareness levels among all staff had significantly increased, and that regular condom use was now considered fashionable. Although not mandatory, every officer was encouraged to wear a condom wallet on their belts as a part of the regular uniform. Most officers do so, although a few reported initial suspicions from their spouses.

The program continues to expand. At several stations, family members have been included in discussions about HIV prevention. In at least two stations, officers have invested their own resources to expand awareness activities to community members. Finally, the CEPS plans to set up an HIV counseling and testing site for its officers and hopes to expand that service to other sites. In the meantime, officers are encouraged to use HIV counseling and testing services available in communities in the country.

Ghana's CEPS HIV/AIDS initiative is a good start. It helps put CEPS staff in the forefront of HIV/AIDS public sector workplace programs in the country. Yet the identified risk factors indicates that even further action is needed to safeguard personnel. For example, issues related to HIV prevention and care should be a regular item on the agenda of senior management meetings. The cost and additional training implications of expanding HIV counseling and testing for staff is one item requiring management attention. As Ghana expands its ART treatment, CEPS management will want to plan for the cost implications. Another issue the service needs to consider is changes in transfer procedures to minimize family separations, while still enabling officers to gain the skills and experiences required for promotions.

#### **CASE STUDY 2: HIV/AIDS PREVENTION WITH CAMBODIA'S MILITARY AND POLICE**

After a devastating cycle of genocide and civil war in the 1970s and 1980s, during which more than 1.5 million people lost their lives, Cambodians were at high risk for HIV/AIDS. Social institutions and services had been disrupted, families were scattered around the country or outside the country, and political and governmental leadership was slowly being rebuilt. In these circumstances, it was not surprising that by the end of the 1990s Cambodia had the highest HIV prevalence in

Asia, estimated at about 4 percent of all adults; specialists feared that the impact of the epidemic would add another dimension to Cambodia's problems of reconstruction and reconciliation.

Of particular concern was the role of men in Cambodia's military and other uniformed services. Surveys found 7 percent of men in the services were HIV-positive, which was higher than the national average. As elsewhere, men in the uniformed services were at increased risk for contracting and spreading HIV because of their mobility and their relative wealth compared to a large portion of the population. Further, it was common for unmarried men in their late teens and early twenties to patronize sex workers. Karaoke bars, brothels, and guesthouses are scattered in the communities near military camps and bases. Surveys in the late 1990s found one-third of sex workers were HIV-infected.

Growing evidence of HIV/AIDS among the military and police forces prompted the government to initiate several prevention interventions. A 100 percent condom policy was instituted, especially in brothels and with sex workers. In 1998, Family Health International began a training program for thousands of male peer educators. Both the national leadership and military and police base commanders supported the program. The commanders identified men they considered peer leaders to receive training as trainers. In addition, some 700 commanders took part in HIV/AIDS sensitivity training. Over time, the commanders provided feedback on the program and the reactions of the men within their units. Without their support and collaboration, the program would not have succeeded.

More than 7,000 peer educators within the uniformed services were trained over a three-year period. They reached nearly two-thirds of all members of the military. These young men

worked with their peers to strengthen negotiation skills in the face of pressure from their comrades to drink in the bars and to patronize of sex workers. They provided information and support on how to assess and reduce the risks associated with HIV infection. Many young men admitted they had little information beforehand about their own risky sexual behavior. Finally, they talked about how AIDS disrupts the lives of individuals, families, and communities, an important point for people in the wake of the killings of an earlier era.

Male-to-male peer education was a key component of the success of HIV/AIDS prevention efforts in Cambodia's uniform services. While men face numerous peer and social pressures to exhibit their sexual prowess, they have little social or interpersonal support for behaving differently. The in-depth peer education program provided support that the men needed to consider their risks and adopt risk-reducing behaviors. And, as more men felt comfortable using condoms, reducing the number of sex partners they had, and postponing sexual activity, social norms too changed.

The evidence points to the contribution of male peer educators in the uniformed services in controlling HIV/AIDS. The percentage of Cambodian military members who had sex with a sex worker in the previous year dropped by more than half between 1998 and 2001, from nearly 70 percent to 32 percent. HIV prevalence among urban police dropped from 6 percent in 1998 to 3 percent in 2002.

The uniformed services peer education program continues, and by early 2004, some 80 percent of all personnel had been involved. Along with other programs at the community level, within the expanding business community, and among women, this peer education program has played a significant role in keeping a potentially devastating epidemic under control.

### **CASE STUDY 3: ZAMBIA'S MINISTRY OF EDUCATION: PROTECTING THE TEACHING SERVICE**

With a national adult HIV/AIDS prevalence of about 20 percent, Zambia's challenge is not only to control the epidemic, but to protect workers in the public sector. The country has about 42,000 teachers, only four-fifths of the level authorized. Already pressed to reach more students and improve the quality of classroom work, the Teaching Service is especially sensitive to the effects of HIV/AIDS.

Studies conducted in the late 1990s indicated that Zambia was losing the equivalent of half of all newly trained teachers each year to HIV/AIDS. Further, many teachers were too ill to teach but remained on the payroll. An estimated one-third of school-age children had lost one or both parents, primarily to HIV/AIDS. In some parts of the country, the percentage was higher. It was not uncommon for children to be withdrawn from school, temporarily or permanently, to help families cope with the effects of HIV. Girls withdrew more frequently than boys.

Beginning in 2000, with leadership from the office of the HIV/AIDS focal point in its headquarters in Lusaka, the Ministry of Education has undertaken a fairly systematic and comprehensive program to address prevention and care for its staff throughout the country. Actions taken to address the epidemic from the Ministry of Education perspective included:

- Publishing an HIV/AIDS Strategic Plan, covering the years 2001–2005
- Preparing HIV/AIDS guidelines for use by teachers and other educators
- Revising curriculum materials for teaching about AIDS in the classroom
- Conducting an HIV/AIDS impact assessment



- Reviewing policy options relevant to the Ministry

The strategic plan included a provision to train select teachers to address the psychosocial needs of orphaned children; it also addressed the need to identify options to replace teachers lost to HIV/AIDS.

All of the documents address HIV/AIDS as a part of the Ministry's efforts to improve the entire education system. AIDS is not simply an add-on to existing functions, but an integral part of the educational process that includes teachers, students and the community.

In the context of protecting teachers, several points stand out in these documents. One of the objectives seeks to bring health services into the school to better serve teachers and students. Another objective, for the Ministry as a whole, is to "audit existing policies, regulations, planning criteria, plans and code of conduct" with the goal of developing "more comprehensive regulations on all aspects of sexual violence and harassment and abuse in schools, colleges and work places." A third objective seeks to deal with the shortfall of teachers by "allowing for alternative learning systems." New resources to cover teacher shortfalls also were to be sought.

Beginning in 1998, Zambia introduced a new approach to teacher training. Previously, students spent two years at a teacher training college in preparation for assuming classroom duties. The teaching included some practical exercises, but the training was largely theoretical. In the new system, students spend their first year in college and the second year in a classroom, where they gain direct experience in working with students. More experienced teachers are assigned as mentors to each student teacher during the year. The program has allowed Zambia to more quickly place more teachers in classroom to make up for the shortfall in overall teaching staff. Although the new system was not designed as a response to

fill gaps due to HIV/AIDS, it has reduced the classroom vacancies that otherwise were occurring.

Concerns have been raised that, in some cases, the mentors themselves are absent and the student teachers do not receive sufficient guidance to prepare them. At the same time, there is general agreement that in a crisis situation, such as with the HIV/AIDS epidemic, innovation, creativity and flexibility are needed to serve both staff and students.

The Zambia National Teachers Union has played an active role in conveying the needs and concerns of teachers to the Ministry of Education. The union initiated the proposal to prepare teachers to address the needs of orphaned and other distressed children. In addition, the union is offering its members a prevention and peer education training program to supplement resources developed by the Ministry.

As a part of its review of existing procedures, the Ministry has examined its sick leave policy. The current policy permitted sick leave for three months at full pay and another three months at half pay. After six months of sick leave, the teacher was expected to leave the service. The policy, while sensitive to the needs of ill individuals, left classrooms vacant or classes doubled up. Headmasters and other supervisors could not hire replacements while a teacher was on sick leave. The Ministry review seeks to identify ways to remain sensitive to sick teachers but assure that children are receiving the education they deserve.

Zambia's Ministry of Education has made substantial progress in providing HIV/AIDS prevention and care programs for its workforce and students. It has begun an important internal review of workplace procedures and regulations that are affected by teacher absenteeism, teacher losses, and demands on benefits, but a more complete response to the impact of the

epidemic of the Teaching Service and other Ministry employees is vitally needed.

#### **CASE STUDY 4: PREVENTION IN AN INDONESIAN BANK**

Bank Tabungan Negara (BTN) is an Indonesian state-owned bank. It specializes in consumer banking and home credit services for more than 5.5 million middle-income and lower-middle income customers. The bank has approximately 2,725 employees who work in 180 branches in major cities and towns across the country. Although HIV/AIDS prevalence is low (less than 1 percent) in Indonesia, many conditions exist for the spread of HIV. The country has experienced increasing prevalence among a growing number of injection drug users and low condom use in the country's large sex industry. Half of the country's known injection drug users were also HIV-infected.

The bank had not experienced staff with HIV/AIDS. However, early in 2003, BTN managers expressed concern about the potential for narcotics-related HIV infections among staff and dependents. With the help of a local NGO, the bank began an HIV and narcotics prevention program. The program sought to train all branch managers to set up prevention programs in every office. Through the program, the bank also intends to reduce stigma and discrimination associated with HIV infection and narcotic use, and to improve access to HIV counseling and testing, treatment, care and support services in the community.

BTN's prevention program was only a year old in early 2004. However, Bank Tabungan Negara now stands as the first Indonesian example of a publicly owned institution engaging in HIV/AIDS prevention. One of the most important aspects of the program is management's commitment to have the framework of a prevention program in place well before HIV becomes a threat to the bank's skilled workforce.

The program began by training all branch managers and some volunteer human resource managers in the basics of HIV/AIDS and injection drug use and in the techniques for communicating behavior change messages to workers. The bank managers are now training other peer educators who interact with all employees. The peer education training includes providing information on community-based services for HIV counseling and testing. The bank's monthly newsletter features prevention information and lists support services available in major cities.

The training occurs during regularly scheduled semiannual management meetings, which regional managers always attend. During these meetings, some branch managers have been trained in the techniques and methods of peer education.

During the training events, lively discussions have dealt with many issues that could be covered by a workplace HIV/AIDS policy. Due to rigid procedures in introducing new policies in state-owned companies, the bank has not developed an HIV/AIDS policy. In lieu of a policy, BTN and its managers have committed to following a non-written set of standards. These include:

- **Nondiscrimination in hiring and employment:** HIV status would not be a basis for decisions on hiring or on a worker's continued employment.
- **Confidentiality and disclosure:** The confidentiality of individuals affected by HIV/AIDS or drug addiction is assured.
- **Benefits:** Existing health coverage will be continued for people with HIV/AIDS or opportunistic infections. The company medical benefits do not, to date, include ART for employees and dependents, but the issue may arise in the future.

- **Ill-health retirement:** The company follows national labor laws stipulating that companies continue the salary of employees for one year after they terminate on medical grounds.

BTN's prevention efforts extend into the community. It has sponsored train-the-trainer workshops in major state-owned housing estates where it is the primary financier. BTN believes that community prevention protects the bank's assets. Customers who become too sick to work, who invest heavily in medical care, or who die may default on their loans.

The bank also believes that its HIV/AIDS and drug prevention program will yield significant

financial benefits, over the cost of investing in the program. By October 2004 the bank expects to spend about \$13,400 on its prevention initiative. That comes to about \$3.25 per employee. It has calculated, however, that one case of AIDS will cost about \$3,500 in treatment expenses for major opportunistic infections, absenteeism, and decreased productivity, not counting medical retirement benefits and new-hire and training costs. Because drug-related rehabilitation is even more expensive, BTN feels that the investment in prevention will pay off.

## **ANNEX 1: SAMPLE POLICY. BOTSWANA'S CODE OF GOOD PRACTICE: SEXUAL HARASSMENT IN THE WORKPLACE\***

### **Introduction**

1.1. This Code is published in terms of section 49 of the Trade Disputes Act. (Chapter 48:02)

1.2. The objective of this Code is to eliminate sexual harassment in the workplace.

1.3. This Code promotes the development and implementation of policies and procedures that should lead to the creation of a workplace—

1.3.1. that is free of sexual harassment;

1.3.2. in which the employer respects the employee's right to dignity, privacy and equity; and

1.3.3. in which employees respect one another's right to dignity, privacy, and equity.

1.4. Sexual harassment constitutes a breach of contract and a delictual wrong. This means—

1.4.1. that an employee who is harassed may—

(a) resign and claim compensation for constructive dismissal;

(b) sue for damages for breach of contract or an invasion of privacy;

(c) interdict the harasser or the employer;

1.4.2. that an employer may lawfully discipline or dismiss an employee who is found to have been guilty of sexual harassment.

1.5. Sexual harassment constitutes a trade dispute in that it may concern a grievance or dispute over—

1.5.1. the application of the common law relating to employment;

1.5.2. the conditions of employment under which an employee may be required to work because of the common law duty to provide safe working conditions;

1.5.3. dismissal. If an employee who is harassed resigns because it is intolerable to continue working for that employer, that resignation may constitute a constructive dismissal that is wrongful.

1.6. This Code provides guidance by summarising some of the provisions of the law and providing guidelines on good practice. If there is any conflict between the provisions of any legislation and this Code, the provisions of the legislation must prevail.

1.7. The guidelines should be followed and may be departed from only if there is good reason to do so. Anyone who departs from them should demonstrate reasons for doing so.

### **2. Application of the Code**

2.1. Although this Code is intended to guide employers and employees, it also applies to perpetrators and victims of sexual harassment who may extend beyond the workplace such as—

2.1.1. job applicants;

2.1.2. clients (including patients, students etc);

2.1.3. suppliers;

2.1.4. contractors;

2.1.5. other people dealing with the organisation

2.2. Clause 2.1 does not confer authority on an employer to take disciplinary action against persons who are not employees. The employer

\* Reprinted from Botswana's National Industrial Relations Code Of Good Practice, Trade Disputes Act, Approved: August 23, 2002.

should however take steps to prevent employees from being harassed and should consider steps against the employer of a perpetrator.

2.3. Sexual harassment constitutes serious misconduct that may entitle an employer to dismiss the employee without notice in terms section 26(1) of the Employment Act.

2.4. The employer must ensure that legitimate channels or procedures exist for victims of harassment to lodge grievances and that they may do so without victimisation.

2.5. This Code is not intended to replace any collective agreement that prohibits sexual harassment in the workplace. It should, however, be taken into account in the negotiation of any collective agreement and in its interpretation by an arbitrator or the Industrial Court.

### **3. Definition of Sexual Harassment**

3.1. Sexual harassment is unwanted conduct of a sexual nature. The unwanted nature of the conduct distinguishes it from consensual behaviour.

3.2. Sexual attention becomes sexual harassment if—

3.1.1. the behaviour is persisted in, although a single incident of harassment can constitute sexual harassment;

3.1.2. the recipient has made it clear that the behaviour is not wanted; or

3.1.3. the perpetrator should have known that the behaviour is regarded as unacceptable.

### **4. Forms of Sexual Harassment**

4.1. Sexual harassment may include unwelcome physical, verbal or non-verbal conduct, and is not limited to the examples listed below:

4.1.1. Physical conduct constituting sexual harassment includes all unwanted physical

contact, ranging from touching to sexual assault and rape, and includes a strip search by or in the presence of the opposite sex;

4.1.2. Verbal forms of sexual harassment include the following types of statements made in the presence of a person or directed toward that person:

4.1.2.1. unwelcome innuendoes, suggestions and hints;

4.1.2.2. sexual advances, sex related jokes or comments with sexual overtones;

4.1.2.3. insults or unwelcome graphic comments about a person's body or sexual orientation;

4.1.2.4. inappropriate enquiries about a person's sex life or sexual orientation.

4.1.3. Non-verbal forms of sexual harassment include the following unwelcome conduct:

4.1.3.1. whistling;

4.1.3.2. sexual gestures;

4.1.3.3. indecent exposure; and

4.1.3.4. the display of sexually explicit pictures and objects.

4.1.4. Sexual harassment in the form of "quid pro quo harassment" occurs when an owner, a person of authority or a co-employee attempts to influence any employment related decision affecting an employee in exchange for a sexual favour. Those decisions include a decision to employ, promote, train, discipline, improve terms and conditions of employment or benefits, transfer or dismiss an employee or job applicant.

4.2. Sexual harassment in the form of sexual favouritism exists if a person who is in a position of authority rewards only those who respond to that person's sexual advances, or other deserving employees who do not submit themselves to any sexual advances, are denied

those rewards. These rewards may be in the form of access to employment opportunities, promotions, merit rating, salary increases etc.

4.3 Sexual harassment warranting disciplinary action includes harassment by an employee of another employee outside of working hours or off work premises, if it impacts on the employment relationship. In these cases, it will be no defence to the disciplinary charges for the alleged perpetrator to claim that the conduct occurred outside working hours or off work premises.

## 5. Guiding Principles

5.1. An employer should create and maintain a working environment in which the dignity of each employee is respected. A climate in the workplace should also be created and maintained in which victims of sexual harassment will not fear reprisals or feel that their grievances are ignored or trivialised. Implementing and publicising the following guidelines at the workplace may assist in achieving these ends:

5.1.1. All employees are required to refrain from committing acts of sexual harassment;

5.1.2. All employees have a role to play in contributing towards creating and maintaining a working environment in which sexual harassment is unacceptable. They should ensure that their standards of conduct do not cause offence and they should discourage unacceptable behaviour on the part of others;

5.1.3. The employer should take steps to ensure that persons such as customers, suppliers, job applicants and others who have dealings with the business, are not subjected to sexual harassment by any of its employees;

5.1.4. The employer must take appropriate action in accordance with this code if sexual harassment occurs in the workplace.

## 6. Policy Statement

6.1. In the absence of a collective agreement, every employer should, as a first step in expressing concern and commitment to prevent sexual harassment in the workplace, issue a policy statement which should endorse the provisions of this Code.

6.2. The policy statement should be communicated to all employees and displayed in a way that it can be seen by employees and non-employees who visit the workplace.

6.3. The policy statement should provide that—

6.3.1. all employees, job applicants and other persons who have dealings with the organisation, have the right to be treated with dignity;

6.3.2. sexual harassment in the workplace will not be permitted or condoned; and

6.3.3. persons who have been subjected to sexual harassment in the workplace have the right to raise a grievance about it and have appropriate action taken against the harasser by the employer.

6.4. The employer should identify a senior employee responsible for implementing the policy and should place that employee under a positive duty to implement the policy and ensure that fair and consistent disciplinary action is taken against employees who do not comply with the policy.

6.5. The policy statement should also explain the procedure which should be followed by employees who are victims of sexual harassment, including:

6.5.1. allegations of sexual harassment will be dealt with seriously, expeditiously, sensitively and confidentially; and

6.5.2. employees will be protected against victimisation, retaliation for lodging grievances and from false accusations.

## 7. Procedures

7.1. Every employer should develop a clear procedure to deal with sexual harassment. The procedure may be incorporated into an existing grievance or disciplinary procedure.

7.2. The procedure should take the provisions of this clause into account.

### 7.3. Advice and Assistance

7.3.1. Sexual harassment is a sensitive issue and a victim may feel unable to approach the perpetrator, lodge a formal grievance or turn to colleagues for support. If possible, employers should designate a person outside of line management whom victims may approach for confidential advice. Such a person—

7.3.1.1. could include persons employed by the organisation to perform, among others, such a function, a trade union representative or co-employee, a member of the human resources department or an outside professional;

7.3.1.2. should have the appropriate counselling and labour relations skills and experience, and be given adequate resources;

7.3.1.3. should be able to provide support and advice on a confidential basis.

### 7.4. Options to resolve a problem

7.4.1. Employees should be advised of two broad options to resolve a problem relating to sexual harassment, namely in an informal way or in terms of a formal procedure. The employee should be under no duress to accept one or other option.

7.4.2. In more serious cases it may not be appropriate to try and resolve the problem informally, such as cases involving sexual assault, rape, a strip search and quid pro quo harassment.

### 7.5. Informal procedure

7.5.1. It may be sufficient for the employee concerned to have the opportunity to explain to the person engaging in the unwanted conduct that the behaviour in question is not welcome, that it is offensive or makes the employee feel uncomfortable, and that it interferes with work. The person against whom the grievance is lodged should then be given an opportunity to apologise for the conduct and to provide a commitment that it will not happen again.

7.5.2. If the informal approach has not provided a satisfactory outcome or if the conduct continues, it may be appropriate to embark upon a formal procedure.

### 7.6. Formal procedure

7.6.1. A formal procedure for resolving a grievance should be available and should—

7.6.1.1. specify to whom the employee should lodge the grievance;

7.6.1.2. make reference to time-frames to allow the grievance to be dealt with expeditiously;

7.6.1.3. notify the victim that if the dispute is not resolved satisfactorily, the dispute may be referred in terms of the Trade Disputes Act for resolution.

### 7.7. Investigation and disciplinary action

7.7.1. Disciplinary action taken against an alleged harasser should follow an established procedure or the procedures set out in the Code on Termination of Employment.

7.7.2. The range of disciplinary sanctions to which employees will be liable should be clearly stated in any policy or procedure, and it must also be made clear that it is a disciplinary offence to victimise or retaliate against an employee who in good faith lodges a grievance of sexual harassment.



7.7.3. The Code on Termination of Employment provides that an employee may be dismissed for serious misconduct or repeated offences. A serious incident of sexual harassment or continued harassment after warnings may justify dismissal.

#### 7.8. Criminal charges and civil claims

7.8.1. A victim of sexual assault may have the right to press separate criminal charges or to institute civil legal proceedings against an alleged perpetrator, and the legal rights of the victim are in no way limited by this Code.

7.8.2. The fact that an employee has laid a charge or instituted civil legal proceedings does not affect the employer's duty to take appropriate action as soon as possible, including disciplinary action against an employee who has been accused of sexual harassment in the workplace.

7.8.3. An employee who is subject to criminal proceedings for sexual harassment, may exercise the right to remain silent in any disciplinary proceedings. If the employee remains silent, the employer is entitled to take disciplinary action, including dismissal, based on any other evidence led in the disciplinary proceedings.

#### 7.9. Referral to adjudication

7.9.1. If a complaint of alleged sexual harassment is not resolved to the satisfaction of the complainant, the complainant may refer the matter as a trade dispute to the Office of the Labour Commissioner for mediation in accordance with the provisions of the Trade Disputes Act. Should the dispute remain unresolved after mediation, the Labour Commissioner must refer the matter to the Industrial Court in terms of the Act.

7.9.2. Any employee dismissed on grounds of sexual harassment has the right to chal-

lenge the fairness of that dismissal in terms of the Act.

### 8. Confidentiality

8.1. Employers and employees must ensure that grievances about sexual harassment are investigated and handled in a manner that keeps confidential the identities of the persons involved.

8.2. In cases of sexual harassment, the employer, employees and the parties concerned must endeavour to ensure confidentiality in the disciplinary enquiry. Only appropriate members of management as well as the aggrieved person, representatives of the parties, the alleged perpetrator, witnesses and an interpreter if required, may be present in the disciplinary enquiry.

8.3. Employers are required to disclose to any party or to their representatives, such information as may be reasonably necessary to enable the parties to prepare for any proceedings in terms of this Code.

### 9. Information and Education

9.1. The Office of the Commissioner of Labour should ensure that copies of this Code are accessible and available.

9.2. Employers and employer organisations should include the issue of sexual harassment in their orientation, education and training programmes of employees.

9.3. Trade unions should include the issue of sexual harassment in their education and training programmes of shop stewards and employees.





## ANNEX 2: WHAT IS BEHAVIOR CHANGE COMMUNICATION?\*

Promoting changes in the behaviors and attitudes that surround HIV/AIDS can be a long-term process. It requires using various communication techniques and targeting select audiences with appropriate messages. The term for these methods is behavior change communication (BCC).

Effective BCC will:

- **Increase knowledge.** BCC provides people with the basic facts in a language, visual medium or other media that they can understand and with which they can identify. Effective BCC motivates audiences to change their behaviors in positive ways.
- **Stimulate community dialogue.** Effective BCC encourages community and national discussions on the underlying factors that contribute to the epidemic, such as risk behaviors, risk settings, and the environments that create these conditions. BCC should create a demand for information and services, and should spur action for reducing risk, vulnerability and stigma.
- **Promote advocacy.** Through advocacy, BCC can ensure that policymakers and opinion leaders approach the epidemic seriously. Advocacy takes place at all levels, from the national level down to the local community level.
- **Reduce stigma and discrimination.** Communication on HIV/AIDS seeks to influence social responses that will reduce stigma and discrimination.
- **Promote services for prevention, care and support.** BCC can promote services that address STIs, orphans and vulnerable children, counseling and testing, mother-to-child

transmission, support groups for PLHA, clinical care for opportunistic infections, and social and economic support. BCC can also improve the quality of these services by supporting providers' counseling skills and clinical abilities.

### The Goals of Behavior Change Communication

BCC strategies in HIV/AIDS aim to create a demand for information and services relevant to preventing HIV transmission, and to facilitate and promote access to care and support services.

Some specific BCC objectives include:

- Increasing the adoption and continued use of safer sex practices
- Promoting visits to clinics treating STIs and opportunistic infections, including tuberculosis
- Increasing the demand for HIV counseling and testing for HIV/AIDS, for mother-to-child HIV/AIDS prevention services, and for orphan care and support
- Increasing the adoption and continued use of safer drug-injection practices;
- Stimulating dialogue and discussion on risk, risk behavior, risk settings and local solutions
- Reducing stigma and discrimination for those living with HIV/AIDS.

### Lessons Learned

Experience in carrying out BCC interventions around the world and in many different societies has shown that:

\* Adapted from the Family Health International website ([www.fhi.org](http://www.fhi.org)).

- BCC should be integrated with overall program goals and specific objectives. BCC is an essential element of HIV/AIDS prevention, care, and support programs, providing critical links with other program components. BCC should be linked to policy initiatives and service provision.
- BCC should encourage individual behavior change and also help create environmental conditions that facilitate personal risk reduction.
- Formative assessment or audience research must be conducted to better understand the needs of the target population and the barriers to behavior change that its members face.
- The target population and the related community should participate in every phase of BCC development.
- Using a variety of communication channels is more effective than relying on any one. For example, peer education should be promoted by mass media, counseling and other approaches.
- Pre-testing is essential for developing effective BCC materials.
- Monitoring and evaluation should be incorporated at the start of any BCC program.
- Objectives for change after exposure to the communication should be specified. These may be changes in actual behavior or shifts in the precursors to behavior change, such as in knowledge or attitudes.
- Fear campaigns do not work. They contribute to an environment of stigma and discrimination, and all BCC in HIV/AIDS should contribute to stigma reduction.
- Because society-wide change is slow, changes achieved through BCC will not be seen overnight.

### **Essential Steps to Develop a Behavior Change Communication Strategy**

The following steps incorporate careful analysis, feedback and redesign throughout the entire process:

- Step 1: Identify the problem based on the overall program goals.
- Step 2: Segment target populations.
- Step 3: Engage in formative research.
- Step 4: Identify behavior change goals.
- Step 5: Seek consensus from stakeholders.
- Step 6: Design a communication plan, including objectives, overall theme, specific messages and outlets for dissemination.
- Step 7: Pre-test and revise.
- Step 8: Target communication to specific groups.
- Step 9: Implement the plan.
- Step 10: Monitor and evaluate it.
- Step 11: Seek feedback and make appropriate revisions.

### **In Conclusion**

BCC strategies must be based on overall program goals and objectives. They must move beyond individual communication products to a careful use of many different interventions, products, and channels for a broad community approach.

A BCC strategy that is woven into the overall program and based on sound formative assessment can influence community discussion, social norms and—when services and commodities are in place—individual and community behavior.

Those who plan and implement HIV/AIDS programs should develop strategic approaches that view BCC not as a collection of different, isolated communication tactics, but as a framework of linked approaches that function as part of an integrated, ongoing process.